Bill as Introduced

2007 SESSION

07-0810
01/05

HOUSE BILL ***636-FN***

AN ACT relative to physician credentialing under the managed care law.

SPONSORS: Rep. McLeod, Graf 2; Rep. Nordgren, Graf 9; Rep. DeStefano, Merr 13; Rep. Pantelakos, Rock 16; Rep. Rosenwald, Hills 22; Sen. Odell, Dist 8

COMMITTEE: Commerce

ANALYSIS

This bill allows the health care professional undergoing the formal credentialing process to provide services to patients during the process and to be reimbursed for such services upon verification of a clean credentialing record.

Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

07-0810
01/05

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Seven

AN ACT relative to physician credentialing under the managed care law.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 Managed Care Law; Credentialing Verification. Amend RSA 420-J:4, I(b) to read as follows:

(b) Verify the credentials of a health care professional [~~before the health care professional~~] with whom the health carrier is contracting [~~provides health services to covered persons~~]. The medical director of the health carrier or other designated health care professional shall have responsibility for, and shall participate in, health care professional credentialing verification. ***Upon verification of the health care professional's credentials, the contracting health carrier shall reimburse the health care professional for services provided to covered persons on the date the health professional submitted a clean and complete credentialing application.***

2 Effective Date. This act shall take effect 60 days after its passage.

LBAO
07-0810
01/29/07

HB 636-FN - FISCAL NOTE

AN ACT relative to physician credentialing under the managed care law.

FISCAL IMPACT:

The Office of Legislative Budget Assistant is unable to complete a fiscal note for this bill as it is awaiting information from the Department of Health and Human Services. When completed, the fiscal note will be forwarded to the House Clerk's Office.

Amendments

Rep. D. Flanders, Belk. 4
March 19, 2007
2007-0798h
01/09

Amendment to HB 636-FN

Amend the bill by replacing section 1 with the following:

1 Managed Care Law; Credentialing Verification. Amend RSA 420-J:4, I to read as follows:

I. A health carrier shall:

(a) Establish written policies and procedures for credentialing verification of all health care professionals with whom the health carrier contracts and apply these standards consistently.

(b) Verify the credentials of a health care professional [~~before the health care professional with whom the health carrier is contracting provides health services to covered persons~~]. ***Prior to completion of credentialing verification the health carrier shall:***

(1) Allow a health care provider who, at the time of application, has been licensed by the respective state licensing board and credentialed by the hospital, if appropriate, to deliver health care services to covered persons and seek reimbursement for such professional services, when covering on-call for another health care provider who is credentialed by the carrier.

(2) Allow a health care provider to deliver health care services to covered persons and seek reimbursement for such services, when that health care provider has been licensed by his or her respective state licensing board and credentialed by the hospital, if appropriate, and who at the time of application is credentialed by the health carrier in another state or is in the health carrier's New Hampshire network based on employment with a particular health care entity. When a health care provider relocates or opens an additional office and the carrier requires a site visit, documentation of the new site evaluation shall be required as part of the credentialing process. The medical director of the health carrier or other designated health care professional shall have responsibility for, and shall participate in, health care professional credentialing verification.

(c) Establish a credentialing verification committee consisting of licensed physicians and other health care professionals to review credentialing verification information and supporting documents and make decisions regarding credentialing verification.

(d) Make available for review by the applying health care professional upon written request all application and credentialing verification policies and procedures.

(e) Retain records and documents relating to a health care professional's credentialing verification process for 7 years.

(f) Keep confidential all information obtained in the credentialing verification process,

except as otherwise provided by law.

(g) Notify a health care provider that a submitted credentialing application is incomplete, not later than 15 business days after receiving the credentialing application.

(h) Act upon and finalize the credentialing process within 30 calendar days for primary care physicians and 45 days for specialists of receipt of a clean and complete application. In this section, "clean and complete" means an application signed and appropriately dated by the health care provider, that includes all of the applicable information required in paragraph II and any affirmative responses on questions related to quality and clinical competence shall contain explanations satisfactory to the carrier.

2007-0798h

AMENDED ANALYSIS

This bill allows the health care professional undergoing the formal credentialing process to provide services to patients during the process and to be reimbursed for such services upon verification of a clean credentialing record. This bill also establishes a time period within which the credentialing process is to be completed.

Speakers

SIGN UP SHEET

To Register Opinion If Not Speaking

Bill # HB 636-FN Date 3-15-07

Committee Commerce

**** Please Print All Information ****

Name	Address	Phone	Representing	Pro	Con
Maura Weston	122 School St, Concord	224.4077	Derry Medical	✓	
Rep Tousis Pantelakos	Dist 16		Ports	✓	

Hearing Minutes

HOUSE COMMITTEE ON COMMERCE

PUBLIC HEARING ON HB 636-FN

BILL TITLE: relative to physician credentialing under the managed care law.

DATE: March 15, 2007

LOB ROOM: 302 **Time Public Hearing Called to Order:** 1:30 pm

Time Adjourned: 2:03 pm

(please circle if present)

Committee Members: Reps. Reardon, DeStefano, Kopka, McEachern, Butler, J. Hammond, Houde, Matheson, Nord, Spratt, Warren, Winters, Hunt, Belanger, D. Flanders, Charles Clark, Marshall Quandt, Matthew Quandt, Martin and Pelkey.

Bill Sponsors: Reps. McLeod, Nordgren, DeStefano, Pantelakos, Rosenwald and Sen. Odell

TESTIMONY

* Use asterisk if written testimony and/or amendments are submitted.

Rep. Stephen De Stefano, co-sponsor – Introduced the bill and submitted written testimony for Rep. Martha McLeod, prime sponsor.

Rep. Jill Hammond – Supports the bill. Monadnock Community Hospital, CFO, raised financial implications of credentialing. Hospital would eat costs; cost shifting evident; if hospital part of network should be covered.

Janet Monahan, NH Medical Society - Supports the bill. When physician comes to New Hampshire it takes three months credentialing or more. Compromise in amendment; allows on-call reimbursement.

Andy Patterson/Leslie Melby, LRG Healthcare & New Hampshire Hospital Assn. – Support the bill as amended; aware of a problem of on-call coverage. Credentialing begins with primary source verification; licensing goes through licensing board, hospital. The exact health plan CAQH process goes across most health carriers; Medicare allows practice before billing number assigned.

Q: Physician hired process?

A: License, hospital privileges then carriers.

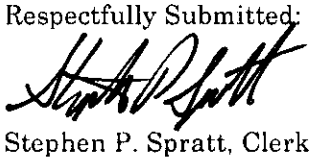
***Mark Vattes, Anthem, BCBS** – Opposes the bill; submitted written testimony. Comfortable with the amendment. Normally credential in 30 days.

Q: Could state license not qualify?

A: Yes, in very rare occasions.

Liz Murphy, Cigna – Supports most of amendment; would like to fine tune. The issue is more complex than it appears.

Respectfully Submitted:



Stephen P. Spratt, Clerk

HOUSE COMMITTEE ON COMMERCE

PUBLIC HEARING ON HB 636-FN

BILL TITLE: relative to physician credentialing under the managed care law.

DATE: March 15, 2007

LOB ROOM: 302 **Time Public Hearing Called to Order:** {Time} 1:30

Time Adjourned: {Time} 2:03

FLANDERS, NORD, HOUDE

(please circle if present)

Committee Members: Reps. Reardon, DeStefano, Kopka, McEachern, Butler, J. Hammond, Houde, Matheson, Nord, Spratt, Warren, Winters, Hunt, Belanger, D. Flanders, Charles Clark, Marshall Quandt, Matthew Quandt, Martin and Pelkey.

Bill Sponsors: Reps. McLeod, Nordgren, DeStefano, Pantelakos, Rosenwald and Sen. Odell

TESTIMONY

* Use asterisk if written testimony and/or amendments are submitted.

(1) CO-SPONSOR - RE DESTEFANO - (FOR PRIME SPONSOR REP. MCLEOD) WT (SEE FILE COPY)

(F) (2) REP. HAMMOND - MONADNOCK COMMUNITY HOSPITAL - CFO RAISED FINANCIAL IMPLICATIONS OF CREDENTIALING - HOSPITAL WOULD EAT COSTS - COST SHIFTING EVIDENT - IF HOSPITAL PART OF NETWORK SHOULD BE COVERED

(F) (3) JANET MONAHAN - NH MEDICAL SOCIETY - WHEN PHYSICIAN COMES TO NH TAKES 3 MOS. CREDENTIALING OR MORE. - COMPROMISE IN AMENDMENT ALLOWS ON-CALL REIMBURSEMENT

(4) ANDY PATTERSON/LESLIE MELBY - AWARE OF PROBLEM OF ON-CALL COVERAGE - ANDY - LRG HEALTHCARE V.P. - CREDENTIALING BEGINS W/ PRIMARY SOURCE VERIFICATION - LICENSING GOES THROUGH LICENSING BOARD, HOSPITAL THE EACH HEALTH PLAN CAQH PROCESS GOES ACROSS MOST HEALTH CARRIERS - MEDICARE ALLOWS PRACTICE BEFORE BILLING # ASSIGNED -
Q - PHYSICIANS HIRED PROCESS
A - LICENSE, HOSPITAL PRIVILEGES THEN CARRIERS

3/15/2007 HB 636-FN

(A) (5) MARK VATTES - ANTHEM B/C B/S - COMFORTABLE WITH AMENDMENT - NORMALLY CREDENTIAL IN 30 DAYS - Q - COULD STATE LICENSE NOT EQUALLY A - YES IN VERY RARE OCCASIONS

(A) (6) LIZ MURPHY - CIGNA - SUPPORTS MOST OF AMENDMENTS WOULD LIKE TO FINE TUNE - ISSUE IS MORE COMPLEX THAN APPEARS

Sub-Committee Actions

HOUSE COMMITTEE ON COMMERCE

SUBCOMMITTEE WORK SESSION ON HB 636-FN

BILL TITLE: relative to physician credentialing under the managed care law.

DATE: March 19, 2007

Subcommittee Members: Reps. Flanders, Nord, and Hammond

Comments and Recommendations: The parties have agreed to the wording of an amendment that clarifies the time frame for the insurance carriers to complete the credentialing process. The meeting was suspended pending receipt of the actual amendment.

Amendments:

Sponsor: Rep. Flanders	OLS Document #:	2007	0798h
Sponsor: Rep.	OLS Document #:		
Sponsor: Rep.	OLS Document #:		

Motions: OTP, OTP/A, ITL, Interim Study (Please circle one.)

Moved by Rep. Hammond

Seconded by Rep. Nord

Vote: 3-0

Motions: OTP, OTP/A, ITL, Interim Study (Please circle one.)

Moved by Rep. Hammond

Seconded by Rep. Nord

Vote: 3-0

Respectfully submitted,

Rep. Don Flanders
Subcommittee Chairman/Clerk

HOUSE COMMITTEE ON COMMERCE

SUBCOMMITTEE WORK SESSION ON HB 636-FN

BILL TITLE: relative to physician credentialing under the managed care law.

DATE: {Type DATE} 3/19/07

Subcommittee Members: Reps. {Type NAMES}

FLANDERS, NORD & HAMMOND

Comments and Recommendations:

THE PARTIES HAVE AGREED TO THE WORDING OF AN AMENDMENT THAT CLARIFIES THE TIME FRAME FOR THE INSURANCE CARRIERS TO COMPLETE THE CREDENTIALING PROCESS. THE MEETING WAS SUSPENDED PENDING RECEIPT OF THE ACTUAL AMENDMENT

Amendments:

2007-0798h

Sponsor: Rep. FLANDERS OLS Document #:

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

Motions: (OTP) OTP/A, ITL, Interim Study (Please circle one.)

Moved by Rep. HAMMOND

Seconded by Rep. NORD

Vote: 3-0

Motions: OTP, (OTP/A), ITL, Interim Study (Please circle one.)

Moved by Rep. HAMMOND

Seconded by Rep. NORD

Vote: 3-0

Respectfully submitted,

Rep. {Type NAME}
Subcommittee Chairman/Clerk
DON FLANDERS

Rep. D. Flanders, Belk. 4
March 19, 2007
2007-0798h
01/09

Amendment to HB 636-FN

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except as otherwise provided by law.

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2007-0798h

AMENDED ANALYSIS

This bill allows the health care professional undergoing the formal credentialing process to provide services to patients during the process and to be reimbursed for such services upon verification of a clean credentialing record. This bill also establishes a time period within which the credentialing process is to be completed.

Testimony

FILE COPY

Chair Tara Reardon
Commerce Committee
March 15, 2007

Introduction -- HB 636-FN, relative to physician credentialing under the managed care law

Background:
In order for a physician or other healthcare practitioner to participate in a health plan, he or she must be "credentialed" by each health carrier. This involves obtaining a significant amount of original documentation about the applicant including evidence of graduation from medical school, the physician's license history, malpractice history, status of hospital privileges, specialty board certification, DEA registration certificate and much more.

This is a lot of documentation which takes considerable time to collect. However, many times the timeframe between the physician's submission of a complete application and the health plan's approval of the physician's credentials takes months. In some instances, health plans have taken six months or more to process an application. And in the meantime, the physician is unable to treat patients.

This delay affects access to health care services – particularly primary care. Throughout the state, we're experiencing a shortage of primary care providers. So patients are unable to be treated. And physicians are specifically prohibited from seeing patients, per RSA 420-J:4, I(b) which states that the health carrier must "Verify the credentials of a health care professional **before the health care professional with whom the health carrier is contracting provides health services to covered persons**."

This section of the law ties the hands of physicians who would otherwise provide care to these patients. Furthermore, it prohibits a physician joining a practice to provide on-call coverage for the practice, a critical requirement to serving the community's health care needs.

Proposed Solution:
Hospitals and physicians, represented by the NH Hospital Association and the NH Medical Society, met with the health plans to work out new requirements to facilitate access to care and payment for services. The Department of Insurance worked with the group to come up with workable solutions. The amendment before you today is more specific than HB 636, as introduced.

- It allows a health practitioner to provide on-call services prior to the health plan's verification of the completed application if he or she has already been licensed by the state and credentialed by the hospital when covering on-call for another physician who is credentialed by that same health plan.

- It allows a physician to see patients and be paid for services rendered if he or she is already credentialed by the very same health plan in another state, or if he or she is in the health carrier's New Hampshire network by virtue of employment with a health care entity.

- It requires the health plans to notify the physician within 15 days if the application is incomplete. This informs the physician of problems with the application of which s/he is otherwise unaware.

- And it requires health plans to complete the credentialing process within 30 days of receiving a clean and complete application.

We need physicians in New Hampshire. As the state's population continues to grow, particularly those 55 and older, the need for health care practitioners will continue to grow. Recruiting physicians is difficult and time-consuming. Once they arrive, if they are prohibited from seeing patients or are not getting paid for on-call services for months and months, word gets out, making it even more difficult to recruit. New Hampshire cannot afford to lose physicians and other health care practitioners to other states.

Thank you Madam Chair and members of the committee for your time and I encourage you to pass this legislation as amended.

Martha McLeod

FILE COPY

Proposed Amendment to HB636

RSA 420-J:4 Credentialing Verification Procedures. –

I. A health carrier shall:
(a) Establish written policies and procedures for credentialing verification of all health care professionals with whom the health carrier contracts and apply these standards consistently.
(b) Verify the credentials of a health care professional [~~before the health care professional with whom the health carrier is contracting provides health services to covered persons.~~] **Prior to completion of credentialing verification:**

(i) Allow a health care provider who has been licensed by the respective state licensing board and credentialed by the hospital(s), if appropriate, to deliver health care services to covered persons and seek reimbursement for such professional services, when covering on-call for another health care provider who is credentialed by the carrier;

(ii) Allow a health care provider to deliver health care services to covered persons and seek reimbursement for such services, when that health care provider has been licensed by their respective state licensing board and credentialed by the hospital(s), if appropriate, and who at the time of application is credentialed by the health carrier in another state or is in the health carrier's New Hampshire network based on employment with a particular health care entity. When a health care provider relocates or opens an additional office and the carrier requires a site visit, documentation of the new site evaluation shall be required as part of the credentialing process.

The medical director of the health carrier or other designated health care professional shall have responsibility for, and shall participate in, health care professional credentialing verification.
(c) Establish a credentialing verification committee consisting of licensed physicians and other health care professionals to review credentialing verification information and supporting documents and make decisions regarding credentialing verification.
(d) Make available for review by the applying health care professional upon written request all application and credentialing verification policies and procedures.
(e) Retain records and documents relating to a health care professional's credentialing verification process for 7 years.
(f) Keep confidential all information obtained in the credentialing verification process, except as otherwise provided by law.
(g) Notify a health care provider that a submitted credentialing application is incomplete, not later than 15 business days after receiving the credentialing application.
(h) Act upon and finalize the credentialing process within 30 calendar days of receipt of a clean and complete application. In this section, "clean and complete" means an application signed and appropriately dated by the health care provider, that includes all of the applicable information required in section II. below and any affirmative responses on questions related to quality and clinical competence shall contain explanations satisfactory to the carrier.

II. A health carrier shall obtain verification of at least the following information about the applicant:
(a) Graduation from health care professional school.
(b) Completion of post graduate training (if applicable).
(c) The health care professional's license history in this and all other states.
(d) The health care professional's malpractice history.
(e) The health care professional's practice history.
(f) Current license, certificate of authority, or registration to practice a health care profession in New Hampshire.
(g) Current level of professional liability coverage (if applicable).
(h) Status of hospital privileges (if applicable).
(i) Specialty board certification status (if applicable).
(j) Current Drug Enforcement Agency (DEA) registration certificate (if applicable).

III. A health carrier shall thereafter obtain, at least every 3 years, verification of a participating provider's:
(a) Current license, certificate of authority or registration to practice a health care profession in New Hampshire.
(b) Current level of professional liability coverage (if applicable).
(c) Status of hospital privileges (if applicable).
(d) Current DEA registration certificate (if applicable).
(e) Specialty board certification status (if applicable).

IV. A health carrier shall require all participating providers to notify the health carrier of changes in the status of any items listed in this section at any time, and shall identify for participating providers the individual or department to whom they should report such changes.

V. Whenever a health carrier contracts to have another entity perform the credential verification functions required by this section or applicable rules, the commissioner shall hold the health carrier responsible for monitoring the activities of the entity with which it contracts and for ensuring that the requirements of this section and applicable rules are met.

VI. Nothing in this section shall be construed to require a health carrier to select a health care professional as a participating provider solely because the health care professional meets the health carrier's credentialing verification standards, or to prevent a health carrier from utilizing separate or additional criteria in selecting the health care professionals with whom it contracts.

FILE COPY

New Hampshire Board of Medicine

2 INDUSTRIAL PARK DRIVE, SUITE 8, CONCORD, NH 03301-8520
Tel. (603) 271-1203 Fax (603) 271-6702
TDD Access: Relay NH 1-800-735-2964
WEB SITE: www.state.nh.us/medicine

APPLICATION FOR LICENSURE

INSTRUCTIONS
APPLICATION
and
FORMS

NOTICE!
To All Applicants for Licensure in New Hampshire

All applicants for licensure in New Hampshire are required to submit their background credentials to the Federation Credentials Verification Service (FCVS). FCVS is a service of the Federation of State Medical Boards and was created to help simplify the licensure process for physicians (both MD's and DO's).

FCVS provides a permanent central depository for documents which represent the core credentials of any physician. FCVS will conduct a primary source verification of those documents at the time they are submitted, and the physician will not be required to re-verify that information even if he or she moves to another state. Currently, 59 state medical boards accept FCVS documents in lieu of the applicant providing new original source documents. New Hampshire and 9 other state medical boards require all applicants to use FCVS for verification of their credentials.

Enclosed, or on our website, you will find 2 separate application forms. You should first complete the FCVS application form and forward that directly to FCVS at the address provided within that application. You should expect the verification process to take a minimum of eight weeks.

Be sure to read the instructions carefully and fill out the application completely. Do not omit any information. If you have questions about the FCVS application, you may contact them by calling 1-888-ASK-FCVS. Do not call the Board's office for questions regarding the FCVS application. When all documents have been sufficiently verified, FCVS will forward your credentials package to the Board.

The next step in the application process will be to complete the Board's Application for Licensure. You may submit your Board Application at the same time that you submit your FCVS application. Processing will occur simultaneously. The Board conducts an independent background investigation. The sooner we receive your application, the sooner we can begin processing that background investigation.

We have taken every precaution to avoid asking for repetitive information; however, you must complete every question on the application. If the question does not apply to you, simply write N/A.

The Board believes that FCVS offers a tremendous opportunity for physicians and state medical boards to improve the burdensome and duplicative process currently in place for state by state licensure. By eliminating the re-verification of documents that never change, physicians will benefit from a shortened credentialing process when they relocate or affiliate within other states. Additionally, the Board has incorporated the Common License Application-Form (CLA-F) into its application. This form will make it easier for physicians to apply for licensure in states that utilize this form (CLA-F). New Hampshire is one of the first states to utilize this form, so please contact the other boards to which you want to apply to find out if they have incorporated the CLA-F into their state application.

The Board reviews applications on the first Wednesday of each month. All applications must be complete before they are submitted to the Board for consideration. The agenda for Board consideration is closed at 12:00 P.M. on the day before the Board meets. Applications completed after 12:00 P.M. will be placed on the next month's agenda. Faxed materials are not acceptable.

GENERAL INFORMATION

The licensure process in the State of New Hampshire is conducted jointly by the New Hampshire Board of Medicine (Board) and The Federation of State Medical Boards' Federation Credentials Verification Service (FCVS). All licensure applicants must complete and submit a Board application **and** a separate FCVS application (enclosed).

FCVS Application Process

You must submit an FCVS application to have your "core" credentials verified directly to the Federation's national office (Texas). This verification process is conducted separately and independently by FCVS in accordance with established polices and procedures set forth by the Board. Because the verification process is the most time-consuming task, it is recommended that you submit this application as soon as possible. You will deal directly with FCVS for all aspects of this verification. **Do not contact the Board about your FCVS application.**

The FCVS will verify your applicable credentials from the original, primary source in the following categories (some may not apply):

- Medical Education
- Postgraduate Training
- Clinical Clerkships/Fifth Pathway
- Examination History
- Board Action History
- ECFMG Certification
- Identity

When all information is received and reviewed for accuracy, FCVS forwards a non-interpretive "Physician Information Profile" containing certified photocopies of your credentials directly to the Board. Refer to the enclosed **gray** application entitled "FCVS Instructions, Application and Forms" to complete this credentials verification process. For more information about the FCVS process, or if you need assistance completing the FCVS application, call toll-free 1–888–ASK–FCVS (1–888–275–3287).

Board Application Process

In addition to the FCVS application and process, you must submit additional information directly to the Board. The Board will use this information, along with the FCVS Profile, to assess your qualifications for licensure. Please allow a minimum of 8 weeks for the entire licensure process to be completed. If you have malpractice or disciplinary history, it can take an additional 2 or 3 months for all pertinent documentation to be received.

The Board meets the first Wednesday of each month. Only applications that are complete, including all outside verifications, will be forwarded to the Board for review. Licenses will be issued within 7-10 working days following the Board meeting and are mailed to the address furnished in your application. **You are responsible for notifying the Board office, in writing, if your address changes in the interim.**

Temporary License Application Process

Since the FCVS application process is fairly lengthy, and unless you already have an FCVS profile, you may want to apply for a temporary license in New Hampshire. A temporary license, if issued, is valid for only 6 months and requires you to provide a completed application, with the exception of the FCVS application, and additional information as follows:

(1) Evidence of qualifications as follows:

a. Proof of a full, unrestricted medical license in another state received directly from the state licensing authority; or

b. Certified copies of medical degree diploma, proof of 2 years of postgraduate training which meet the requirements of Med 302.01, and proof that you have passed one of the licensure examinations listed under Med 303.01;

(2) Proof that you have applied to the FCVS with full intent to complete the FCVS process. The Board will accept a letter from you verifying this information; and

(3) The temporary license fee of $50.00. Make check payable to TREASURER, STATE OF NEW HAMPSHIRE. **Please submit one check for the temporary license fee ($50.00) and a separate check for the full license application fee ($250.00).**

****Before applying for the temporary license, please contact the New Hampshire facility you are applying at to confirm that they accept the temporary license.**

**Please continue to review the remaining portions of this application packet (on white paper) for instructions and other materials necessary to completing the Board application. If you have questions about this application process, or would like to check on the status of your Board application, please call the Board at (603) 271-1203.

INSTRUCTIONS FOR COMPLETING THE BOARD APPLICATION

Licensure Requirements

Before completing the application process, please review the following requirements for licensure in New Hampshire:

- Obtained the M.D./D.O. degree or its equivalent as determined by the Board;
- Completed at least 2 years of postgraduate training in the U.S. or Canada approved by the Board, or its equivalent as determined by the Board;
- Successfully passed a national licensing examination sequence (or its acceptable hybrid combination) as approved by the Board on each examination, including:
  - National Board of Medical Examiners (NBME) Part I, II and III;
  - Pre-1985 FLEX or FLEX Component 1 and 2;
  - USMLE Step 1, 2 and 3;
  - NBOME Part I, II and III (or COMLEX);
  - Licentiate of the Medical Council of Canada (LMCC).
  -

If you do not meet, or have questions about these requirements, please contact the Board prior to submitting your application.

General Instructions

1. Make a copy of the application and forms before you begin in case you make a mistake.
2. Type your information or print in blue or black ball-point pen. Board staff will not make assumptions about illegible information.
3. Provide a response to each section or question; otherwise, mark "N/A" for Not Applicable.
4. All documents you submit must be originals, signed on letterhead unless notarized copies are specifically authorized.
5. You will receive an acknowledgment letter once your application has been received. This letter will advise you of what information, if any, is outstanding at that time. If you do not receive an acknowledgment letter within 30 days, please contact the Board between 8:00 A.M. and 4:00 P.M. EST.

Completing your Application

1. Complete the Board Application (pages 1-20). You must respond to all components of the application. **See "Licensure Requirements" above.**

   Make a check or postal or express money order (in U.S. funds only) for the application fee of **$250.00** payable to: Treasurer, State of New Hampshire and staple it to the upper left-hand corner of the first page of the application. This application fee is NON-REFUNDABLE. [NOTE: This is the Board application fee. The FCVS verification fee is an additional and separate fee paid directly to FCVS.]
   (An additional $50.00 fee is required if requesting a temporary license. Please submit one check for the temporary license fee ($50) and a separate check for the full license application fee ($250).)

2. Complete page 10, "Affidavit and Authorization For Release of Information." The affidavit must be signed in the presence of a notary and must have a 2"x2" recent "passport" photograph of yourself securely affixed to the form. [NOTE: The FCVS application also requires a separate Affidavit that

must be notarized. You may wish to have both forms notarized at the same time. Be certain to submit the correct form to the correct agency.]

3. Complete page 12, "Malpractice Liability Claims Information," if applicable. You must use this form to report all claims or suits for medical malpractice made against you **in the last ten years**. The report should be completed in its entirety. Make additional copies of this page as necessary for multiple claims.

4. Obtain a total of four (4) letters of reference attesting to your moral character and professional abilities. These letters must be obtained from the following: the chief of staff (ref. 1) and hospital administrator (ref. 2) in a hospital where you presently hold staff privileges (if no staff privileges are presently held, letters of recommendation shall be submitted by 2 other practicing medical doctors who hold hospital staff privileges); and two (2) additional letters of reference from practicing physicians. **Reference letters must be originals submitted on letterhead. References may be submitted by the applicant or by the physician providing the reference.**

5. Submit a notarized copy of your American Board of Medical Specialty Certificate(s), if applicable.

6. Submit your curriculum vitae.

7. Submit a notarized copy of your current Drug Enforcement Administration (DEA) certificate.

8. Obtain verification from all states where you hold, or have ever held, a license to practice medicine. To obtain this verification, you must mail page 11, "Licensure Verification Form," to each licensing authority in which you are/were licensed. Be certain to sign and complete the identifying information on each form. **These verifications must be received directly from the licensing authority.** You may obtain the mailing address of all 68 medical licensing authorities at the Federation of State Medical Boards' website at *www.fsmb.org*, or by calling the Board in question. Most states charge a fee for verification of licensure. To save time, you should check with the state board before submitting your request. Please do not contact the New Hampshire Board for mailing addresses of other licensing authorities.

9. Complete the "Addendum to Application" (Addendum Pages 1-2).

10. Prepare all application materials as instructed. Do not submit applications without all applicable information and documentation. Mail your application to:

BOARD OF MEDICINE
2 INDUSTRIAL PARK DRIVE, SUITE 8
CONCORD, NEW HAMPSHIRE 03301-8520

Other Information

Your application process is not considered complete until your Board application, licensure verification(s), and FCVS Physician Information Profile are received in a manner satisfactory to the Board. The Board will not accelerate processing of one applicant at the expense of others for any reason. Once completed, your application will be reviewed at the first available Board meeting. Please allow 7-10 working days following the Board meeting for your license to be mailed to you.

Note: **Do NOT make commitments to start practicing medicine in New Hampshire until you have been issued a license.**

Application for Physician Licensure Instructions

Checklist

After completing the enclosed application, you are responsible for submitting the application along with certain documents. There are two different checklists below; one when you are using the Federation Credentials Verification Service and one when you are not using FCVS. Please use the checklist that applies to you.

	State does not require FCVS and you choose not to use FCVS	State requires or accepts FCVS and you are using FCVS
Completed Application (including state addendums)	☐	☐
State Licensure Verification form sent to the Board from all states in which you have ever held any healthcare license	☐	☐
Enclose the completed "Affidavit and Authorization for Release of Information" form with this application when submitting it to the Board	☐	☐
Notarized copy of birth certificate or current, valid passport	☐	completed via FCVS
Medical Education Verification form sent to the Board by all medical schools attended – include a copy of your diploma (must be sealed by your school)	☐	completed via FCVS
Medical school transcripts sent to the Board by your medical school	☐	completed via FCVS
Fifth Pathway (if applicable) form sent to the Board from the medical school and institution – include a copy of your diploma (must be sealed by your school)	☐	completed via FCVS
Postgraduate Training Verification form sent to the Board from all programs you attended	☐	completed via FCVS
Enclose a copy of your postgraduate training certificate with this application when submitting it to the Board	☐	completed via FCVS
Examination transcripts sent to the Board	☐	completed via FCVS
ECFMG (if applicable) Status Report sent to the Board	☐	completed via FCVS

It is your responsibility to immediately notify the board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license being granted to you by the board.

Application for Physician Licensure

1. Name: Indicate your full legal name. If your name has changed at any time during your life and you are not using FCVS, you must submit a copy of the legal document (marriage certificate, divorce decree, etc.) supporting your name change.

1. Full Name (use no initials)

Last Name _____

First Name _____

Middle Name _____

Suffix _____

Maiden Name _____

M.D. ☐ D.O. ☐

_____

All other names used

2. Address/Phone: Please complete all sections and indicate which address you wish to be used for public access and which is to be used for mailings from the medical board. Each state's law determines whether each address or phone number is a public record in the state in which you are applying. You may wish to contact the licensing authority for that state for further information. Many boards publish the "Public Access" address on their website, therefore you should consider what your preferred address is for these purposes.

Practice Address

☐ Public Access

☐ Mailing

Street _____

City _____ State/Province _____ ZIP Code _____

Telephone _____

Fax _____

E-mail address _____

Alternate Phone (e.g. pager or cell phone) _____

Home Address

☐ Public Access

☐ Mailing

Street _____

City _____ State/Province _____ ZIP Code _____

Telephone _____

Fax _____

E-mail address _____

Alternate Phone (e.g. pager or cell phone) _____

3. Identification: If you are not using FCVS, you must submit either a notarized copy of your birth certificate or a notarized copy of your current, valid passport.

3. Identification

Date of Birth (mm/dd/yyyy)	Birth City	Birth State/Province	Birth Country
/ /			

Gender _____ Social Security Number _____ Are you a U.S. Citizen? ☐ Yes ☐ No

Your social security number is required to facilitate reporting to the federal Healthcare Integrity & Protection Data Bank (42 U.S.C. Sections 1320a-7e(b), 5 U.S.C. Section 552a, and 45 C.F.R. pt. 61) and for accurate identification under the federal and state child support enforcement law (42 U.S.C. Section 666 and applicable state law). It may also be used for reporting to the National Practitioner Data Bank (42 U.S.C. Section 11101 and 45 C.F.R. pt. 60) and for other investigative/enforcement purposes in compliance with state laws governing physician discipline or as otherwise required by state or federal law.

4. Medical School: List all medical schools you have attended, even those from which you did not graduate in chronological order. Attach an additional sheet if necessary. If you are not using FCVS, you must complete the attached "Medical Education Verification" form and send it to all medical schools you have attended. You must include a copy of your diploma to which the medical school must attach their seal prior to forwarding it to this Board. Additionally, the medical school must provide this Board with an official copy of your transcripts. The medical school must forward all documentation directly to this Board.

4. Medical School (attach additional pages if necessary)

1. School Name _____
   Address _____
   City _____
   State/Province _____
   ZIP Code _____
   Country _____
   Attendance Dates (From – To) _____
   Graduation Date _____
   Degree _____

2. School Name _____
   Address _____
   City _____
   State/Province _____
   ZIP Code _____
   Country _____
   Attendance Dates (From – To) _____
   Graduation Date _____
   Degree _____

5. Fifth Pathway: If you attended a Fifth Pathway program and are not using FCVS, you must complete the attached "Fifth Pathway Verification" form and send it to your medical school and to the institution where you completed your rotations. You must include a copy of your diploma. The medical school and institution must forward all documentation directly to this Board.

5. Fifth Pathway (if applicable)

Medical School Name _____

Address _____

City _____

State/Province _____

ZIP Code _____

Country _____

Attendance Dates (From - To) _____

Graduation Date _____

Degree _____

Institution name where rotations performed _____

Address _____

City _____

State/Province _____

ZIP Code _____

Country _____

Attendance Dates (From - To) _____

Certification Date _____

Applicant Name: _____ Date: _____

6. Postgraduate Training: List **all** postgraduate programs you have attended, even those you did not complete. Attach an additional sheet if necessary. If you are not using FCVS, you must complete the attached "Postgraduate Training Verification" form and send it to **all** postgraduate training programs you have attended. You must submit a copy of your certificate of program completion to this Board. Additionally, the postgraduate program must provide this Board with the Program Director's recommendation letter. The postgraduate program must forward all documentation directly to this Board.

6. Postgraduate Training (copy and attach additional pages if necessary)

Complete name and address of hospital where training was conducted (Do Not Abbreviate)

1.Hospital Name_____

Hospital Address_____

City_____

State/Province_____

ZIP Code_____

Country_____

PGY: (e.g., 1, 2, 3, etc.) ☐ Internship ☐ Residency ☐ Fellowship ☐ Research ☐ Other

Department/Specialty:_____

From: __/____ To: __/____ Successfully Completed? Yes☐ No☐ In Progress☐

Month Year Month Year

2.Hospital Name_____

Hospital Address_____

City_____

State/Province_____

ZIP Code_____

Country_____

PGY: (e.g., 1, 2, 3, etc.) ☐ Internship ☐ Residency ☐ Fellowship ☐ Research ☐ Other

Department/Specialty:_____

From: __/____ To: __/____ Successfully Completed? Yes☐ No☐ In Progress☐

Month Year Month Year

Applicant Name:_____ Date:_____

6. Postgraduate Training (continued)

3.Hospital Name_____

Hospital Address_____

City_____

State/Province_____

ZIP Code_____

Country_____

PGY: (e.g., 1, 2, 3, etc.) ☐ Internship ☐ Residency ☐ Fellowship ☐ Research ☐ Other

Department/Specialty:_____

From: ____ / ____ To: ____ / ____ Successfully Completed? Yes☐ No☐ In Progress☐

Month Year Month Year

4.Hospital Name_____

Hospital Address_____

City_____

State/Province_____

ZIP Code_____

Country_____

PGY: (e.g., 1, 2, 3, etc.) ☐ Internship ☐ Residency ☐ Fellowship ☐ Research ☐ Other

Department/Specialty:_____

From: ____ / ____ To: ____ / ____ Successfully Completed? Yes ☐ No ☐ In Progress ☐

Month Year Month Year

7. Examination History: If you are not using FCVS, you are responsible for contacting the appropriate examination entity and having a certified transcript of your scores sent directly to this Board.

7. Examination History

List each licensure examination, U.S. or international, you have taken (USMLE, NBME, NBOME, LMCC, Etc.).If additional space is necessary, please enclose a separate sheet with your application and include all the information below.

Examination	Most Recent Date taken(Month/Year)	Passed (P) or Failed (F)	Number of attempts
State Board Exam _____ State	_____	☐ P ☐ F	_____
FLEX Pre-1985	_____	☐ P ☐ F	_____
FLEX Component 1	_____	☐ P ☐ F	_____
FLEX Component 2	_____	☐ P ☐ F	_____
LMCC – Single	_____	☐ P ☐ F	_____
LMCC – Part I	_____	☐ P ☐ F	_____
LMCC – Part II	_____	☐ P ☐ F	_____
NBME Part I	_____	☐ P ☐ F	_____
NBME Part II	_____	☐ P ☐ F	_____
NBME Part III	_____	☐ P ☐ F	_____
SPEX	_____	☐ P ☐ F	_____
NBOME Part I	_____	☐ P ☐ F	_____
NBOME Part II	_____	☐ P ☐ F	_____
NBOME Part III	_____	☐ P ☐ F	_____
COMLEX Level 1	_____	☐ P ☐ F	_____
COMLEX Level 2	_____	☐ P ☐ F	_____
COMLEX Level 3	_____	☐ P ☐ F	_____
COMVEX	_____	☐ P ☐ F	_____
USMLE Step I	_____	☐ P ☐ F	_____
USMLE Step II	_____	☐ P ☐ F	_____
USMLE Step III	_____	☐ P ☐ F	_____

8. ECFMG: If ECFMG is applicable and you are not using FCVS, you are responsible for contacting ECFMG and having a certified "Status Report" forwarded directly to this Board. There is a separate fee for this report. Reports can be obtained through the ECFMG web site at www.ecfmg.org.

8. ECFMG (if applicable)

Certificate Number _____ Issue Date _____ Valid Through Date _____

9. State or Professional Licensure: List all state and Canadian provinces where you currently hold or have ever held any type of medical/osteopathic license. You must also complete the attached "Licensure Verification" form (Form #1) and forward it to all states in which you have held any health care license or certification. The verifying entity must forward all documentation directly to this Board. Some state boards charge a fee for this information. Contact the state board where you hold or held a license to determine their requirements.

9. State Licensure – MD or DO only – attach additional pages if necessary

1. State/Province _____ Type _____ (MD, DO, etc) License Number _____ Status _____ Issue Date _____
2. State/Province _____ Type _____ (MD, DO, etc) License Number _____ Status _____ Issue Date _____
3. State/Province _____ Type _____ (MD, DO, etc) License Number _____ Status _____ Issue Date _____
4. State/Province _____ Type _____ (MD, DO, etc) License Number _____ Status _____ Issue Date _____
5. State/Province _____ Type _____ (MD, DO, etc) License Number _____ Status _____ Issue Date _____
6. State/Province _____ Type _____ (MD, DO, etc) License Number _____ Status _____ Issue Date _____
7. State/Province _____ Type _____ (MD, DO, etc) License Number _____ Status _____ Issue Date _____
8. State/Province _____ Type _____ (MD, DO, etc) License Number _____ Status _____ Issue Date _____
9. State/Province _____ Type _____ (MD, DO, etc) License Number _____ Status _____ Issue Date _____
10. State/Province _____ Type _____ (MD, DO, etc) License Number _____ Status _____ Issue Date _____

Applicant Name: _____ Date: _____

All Other Health Care Licensure/Certification (e.g., RN, PA, etc.) - attach additional pages if necessary.

1. State/Province _____ Type _____ License Number _____ Status _____ Issue Date _____
2. State/Province _____ Type _____ License Number _____ Status _____ Issue Date _____
3. State/Province _____ Type _____ License Number _____ Status _____ Issue Date _____
4. State/Province _____ Type _____ License Number _____ Status _____ Issue Date _____
5. State/Province _____ Type _____ License Number _____ Status _____ Issue Date _____

10. Chronology of Activities: List ALL activities (medical and non-medical) in chronological order beginning with medical school graduation to the PRESENT date, using **MONTH** and **YEAR**. *For any non-working time, you MUST state on the form exactly what your activities were, such as "vacation" or "seeking employment," as well as your permanent address.* If you worked for a physician-staffing group or did locum tenens, you must list all facilities where you worked and include complete dates and addresses. **DO NOT SUBSTITUE ANY OTHER RESUME FOR THIS FORM**. Be sure to indicate the percentage of working time spent in clinical administrative duties.

10. Chronology of Activities (copy and attach additional pages if necessary)

Dates: From/To	Practice/Employment
1. From: Month: _____ Year: _____ To: Month: _____ Year: _____	Practice/Employment Name _____ (or list non-working time as indicated above) Practice/Employment Address _____ City _____ State/Province _____ ZIP Code _____ Country _____ Position and Department _____ % Clinical _____ % Administrative _____ Employment ☐ Staff Privileges ☐ Affiliation ☐ Other _____
2. From: Month: _____ Year: _____ To: Month: _____ Year: _____	Practice/Employment Name _____ (or list non-working time as indicated above) Practice/Employment Address _____ City _____ State/Province _____ ZIP Code _____ Country _____ Position and Department _____ % Clinical _____ % Administrative _____ Employment ☐ Staff Privileges ☐ Affiliation ☐ Other _____

Applicant Name: _____ Date: _____

Dates: From/To	Practice/Employment
3. From: Month: _____ Year: _____ To: Month: _____ Year: _____	Practice/Employment Name _____ (or list non-working time as indicated above) Practice/Employment Address _____ City _____ State/Province _____ ZIP Code _____ Country _____ Position and Department _____ % Clinical _____ % Administrative _____ Employment ☐ Staff Privileges ☐ Affiliation ☐ Other _____
4. From: Month: _____ Year: _____ To: Month: _____ Year: _____	Practice/Employment Name _____ (or list non-working time as indicated above) Practice/Employment Address _____ City _____ State/Province _____ ZIP Code _____ Country _____ Position and Department _____ % Clinical _____ % Administrative _____ Employment ☐ Staff Privileges ☐ Affiliation ☐ Other _____
5. From: Month: _____ Year: _____ To: Month: _____ Year: _____	Practice/Employment Name _____ (or list non-working time as indicated above) Practice/Employment Address _____ City _____ State/Province _____ ZIP Code _____ Country _____ Position and Department _____ % Clinical _____ % Administrative _____ Employment ☐ Staff Privileges ☐ Affiliation ☐ Other _____
6. From: Month: _____ Year: _____ To: Month: _____ Year: _____	Practice/Employment Name _____ (or list non-working time as indicated above) Practice/Employment Address _____ City _____ State/Province _____ ZIP Code _____ Country _____ Position and Department _____ % Clinical _____ % Administrative _____ Employment ☐ Staff Privileges ☐ Affiliation ☐ Other _____

Applicant Name: _____ Date: _____

11. Malpractice Liability Claims Information (copy this for to report multiple claims)

Name of patient involved: _____

In which state did the action take place? _____ Case number (if applicable) _____

Which court? _____
(If private compromise or settled before initiation of civil action, state here)

Current status of claim: _____

☐ Open (pending) ☐ Closed (settled) ☐ Dismissed (no money paid out) ☐ Other _____

Amount of judgement or settlement $ _____ Amount paid on your behalf $ _____

Month and year of event precipitating claim: _____

Month and year of lawsuit: _____

Insurance carrier at time: _____

What is/or was your status? ☐ Primary defendant ☐ Co-defendant ☐ Other _____

Please provide specifics in reference to the adverse event including the allegations and your role in the event:

Applicant Name: _____ Date: _____

Affidavit and Authorization for Release of Information: You must attach a recent (less than 6 months old) passport quality, color photograph of yourself to this form. Take the form to a notary public and sign the form in the presence of the notary public. The notarized form then must be sent directly to this Board.

Affidavit
And
Authorization For Release of Information

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have or shall make with respect thereto are true, that I am the original and lawful possessor and person named in the various forms and credentials furnished or to be furnished with respect to my application and that all documents, forms or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the Application for Physician Licensure and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me to furnish to the Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the Board or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

I hereby release, discharge and exonerate the Board, its agents or representatives and any person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the Board.

I will immediately notify the board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license to practice medicine being granted to me by the board

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my licensure or permit to practice medicine.

_____
Applicant's Signature (must be signed in the presence of a notary)

_____
Applicant's Printed Last Name

_____
Applicant's Printed First Name, Middle Initial, and Suffix (e.g., Jr.)

_____
Date of Signature

Applicant Photograph

Securely tape or glue in this square a current front-view 2" x 2" passport-type color photograph of yourself.

NOTARY

Dated_____ Signed_____

State of_____ County of _____

SUBSCRIBED AND SWORN TO before me this_____ day of, _____ 20____.

My commission expires:_____ (NOTARY PUBLIC SIGNATURE & SEAL)

Licensure Verification Form **Form #1**
(Copy this form for multiple licenses)

I am applying for a license to practice medicine. The Board requires that this form be completed by each state or Canadian province in which I hold or have held licenses, whether now current or not. Please complete the form and return it directly to the following Board:

To be completed by applicant

Applicant Name: _____
Last First Middle Suffix

Date of Birth: _____ Social Security Number: _____ License Number: _____
(From State/Province you are sending this form to)

The applicant's social security number is to be used for purposes of identification and may not be used for any other reason.

I hereby authorize the licensing agency of the State/Province of _____ to furnish the information to the Board indicated below.

Signature of Applicant _____ Date _____

Board Name: _____

Address: _____
Street City State/Province ZIP Code

TO BE COMPLETED BY STATE LICENSING BOARD OR CANADIAN PROVINCE

Name of Licensee: _____
Last First Middle Suffix

License Type: _____ License #: _____ Issue Date: _____ Expiration Date: _____

Is this license current? ☐Yes ☐No If No, please explain: _____

1) Have formal disciplinary proceedings been initiated against applicant's license by a disciplinary authority in your state?
☐Yes ☐No ☐ Cannot answer under state law
If Yes, please explain: _____

2) Has the applicant ever been warned, censured, placed on probation, formal consent, reprimand or in any other manner disciplined; or has the applicant's license ever been revoked, suspended, or in any other manner, limited by a licensing or disciplinary authority in your state?
☐ Yes ☐ No ☐ Cannot answer under state law
If Yes, please explain: _____

Affix Board Seal Here

Board Authorized Signature: _____

Title: _____

Date: _____

Please return this form to the Board listed at the top of this form.

Applicant Name: _____ Date: _____

Medical School Verification – Page 1 of 4

(Copy this form for multiple schools)

Applicant Instructions: For applicants not using FCVS, complete Section 1 and Section 2 of this form then send this form to your medical school along with a copy of your diploma. Request the Dean or designated official to complete Section 3 of this form and return this form, the sealed copy of your diploma (to be sealed by your medical school) and a copy of your official transcripts directly to this Board.

Section 1: Applicant Information

Last Name: _____ First Name: _____ Middle Name: _____

Name if different when diploma awarded: _____

Social Security Number: _____ Date of Birth: _____

The applicant's social security number is to be used for purposes of identification and may not be used for any other reason.

Waiver for release of information: I authorize the Medical School below to provide any and all information pertaining to my medical education at your institution to the below listed Medical Board.

Applicant's Signature _____ Date _____

Section 2: Instructions to the Dean or designated official of medical school

Please complete Section 3 of this form, certify the enclosed copy of the above named applicant's diploma by placing your school seal on it, enclose an official copy of the transcripts of the above named physician and forward all of this information directly to this Board to the following address:

Board Name: _____

Address _____ City _____ State/Province _____ ZIP Code _____

Medical School Verification – Page 2 of 4
(Copy this form for multiple schools)

Section 3: Medical School Verification

Medical School Name: _____

School name if different when the above applicant attended: _____

Medical School Address: _____

Street City State/Province ZIP Code

Hours of undergraduate education required for admission into your school: _____

Applicant's Attendance Dates: From _____ To _____ Graduation Date: _____ Degree: _____

(Indicate N/A if not applicable) (Indicate N/A if not applicable)

Total weeks of education applicant attended your school: _____

I certify that to the best of my knowledge and belief the foregoing is a true, accurate and complete statement of the record of the individual named on this form.

Signature: _____

Print name: _____

AFFIX INSTITUTIONAL SEAL HERE

(If no seal is available, this form must be notarized)

Title: _____

Date: _____

Phone number: _____ Fax: _____

E-mail: _____

VERIFICATION OF MEDICAL EDUCATION

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the individual's medical education. Please check the appropriate response and provide dates and requested information. "Yes" responses to any of these questions require a copy of explanatory records or a written explanation (attach additional pages as necessary).

Medical School Verification – Page 3 of 4
(Copy this form for multiple schools)

1. Does this individual's official records reflect (an) interruption(s) or extension(s) in his/her medical education?

Response ☐ YES ☐ NO

If YES, please select the reason(s) for, indicate the dates of the interruption(s) or extension(s) and check whether the interruption/extension was approved or unapproved.

	From Mo/Yr	To Mo/Yr	Approved	Unapproved
Personal/Family			☐	☐
Academic remediation			☐	☐
Health			☐	☐
Financial			☐	☐
Participation in joint degree Program (e.g., MD/PhD)			☐	☐
Participation in non-research special study (e.g., fellowship, international experience)			☐	☐
Participation in non-degree research			☐	☐
Other			☐	☐

Please Specify: _____

2. Does this individual's official records reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education? Response YES NO

If YES, please select the reason(s) for the probation, indicate the date(s) of placement on and removal from probation and attach additional documentation to this report.

	From Mo/Yr	To Mo/Yr
☐ Academic Probation		
☐ Probation for unprofessional conduct/behavioral		
☐ Probation for other reason		

Please specify reason: _____

3. Does this individual's official records reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? Response ☐ YES ☐ NO

If YES, please provide detailed documentation/information about the circumstances and outcome(s): _____

Medical School Verification – Page 4 of 4

(Copy this form for multiple schools)

4. Does this individual's official records reflect that he/she was ever the subject of negative reports or an investigation by the medical school or parent university? Response ☐ YES ☐ NO

If YES, please provide detailed documentation/information about the circumstances and outcome(s):

5. Does this individual's official records reflect that there were any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason?
Response ☐ YES ☐ NO

If YES, please provide detailed documentation/information about the nature of the limitations or special requirements.

Postgraduate Training Verification - Page 1 of 3

(Copy this form for multiple programs)

Applicant Instructions: For applicants not using FCVS, complete Section 1 and Section 2 of this form then send this form to your training program. Request the Program Director or designated official to complete Section 3 of this form and return this form and the Program Director's recommendation letter directly to this Board.

Section 1: Applicant Information

Last Name: _____

First Name: _____

Middle Name: _____

Name if different when diploma awarded: _____

Social Security Number: _____

Date of Birth: _____

The applicant's social security number is to be used for purposes of identification and may not be used for any other reason.

Waiver for release of information: I authorize the Postgraduate Training Program below to provide any and all information pertaining to my medical education at your institution to the below listed Medical Board.

_____ _____

Applicant's Signature Date

Section 2: Instructions to the PROGRAM DIRECTOR or designated official of POSTGRADUATE TRAINING PROGRAM.

Please complete Section 3 of this form and attach a recommendation letter from the Program Director and forward this information directly to this Board to the following address:

Board Name: _____

Address _____

City _____

State/Province _____

ZIP Code _____

Postgraduate Training Verification - Page 2 of 3
(Copy this form for multiple programs)

Section 3: Postgraduate Training Verification

Institution Name: _____

Institution Address: _____

Street _____

City _____

State/Province _____

ZIP Code _____

Affiliated Medical School Name: _____

Program Type/Specialty: _____

Postgraduate Year: _____

Internship Residency Fellowship Research Chief Resident Other _____

From Date: ____/____/____ To Date: ____/____/____

Successfully Completed?: Yes No In Progress
(The definition of Successfully Completed is: In each year of training, did the applicant demonstrate sufficient academic and clinical ability to qualify for advancement without conditional or probationary status to the next year and next progressive level of responsibility in a designated specialty program?)

Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Unusual Circumstances:

Did this individual ever take a leave of absence or break from his/her training?	☐ Yes	☐ No
Was this individual ever placed on probation?	☐ Yes	☐ No
Was this individual ever disciplined or placed under investigation?	☐ Yes	☐ No
Were any negative reports ever filed by instructors?	☐ Yes	☐ No
Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason?	☐ Yes	☐ No

Please explain any "Yes" response from above (attach additional pages if necessary): _____

_____

_____

_____

_____

Postgraduate Training Verification - Page 3 of 3

(Copy this form for multiple programs)

I certify that to the best of my knowledge and belief the foregoing is a true, accurate and complete statement of the record of the individual named on this form.

Signature: _____

Print name: _____

Title: _____

Date: _____

Phone number: _____

Fax: _____

E-mail: _____

AFFIX INSTITUTIONAL SEAL HERE (If no seal is available, this form must be notarized)

Form #4

If you completed Section 5 of the application, you must complete this form

Fifth Pathway Verification

Applicant Instructions: For applicants not using FCVS, complete Section 1 and Section 2 of this form then send this form to the director of your 5th Pathway Program. Request the Program Director or designated official to complete Section 3 of this form and return this form and the Program Director's recommendation letter directly to this Board.

Section 1: Applicant Information

Last Name: _____

First Name: _____ Middle Name: _____

Name if different when diploma awarded: _____

Social Security Number: _____

Date of Birth: _____

The applicant's social security number is to be used for purposes of identification and may not be used for any other reason.

Waiver for release of information: I authorize the Postgraduate Training Program below to provide any and all information pertaining to my medical education at your institution to the below listed Medical Board.

_____ _____

Applicant's Signature Date

Section 2: Instructions to the PROGRAM DIRECTOR or designated official

Please complete Section 3 of this form and attach a recommendation letter from the Program Director and forward this information directly to this Board to the following address:

Board Name: _____

Address _____

City _____

State/Province _____ ZIP Code _____

Section 3: Medical School Verification

Medical School Name: _____

School name if different when the above applicant attended: _____

Applicant's Attendance Dates: From _____ To _____ Program Completion Date: _____
(Indicate N/A if not applicable)

I certify that to the best of my knowledge and belief the foregoing is a true, accurate and complete statement of the record of the individual named on this form.

Signature: _____

Print name: _____

AFFIX INSTITUTIONAL SEAL HERE

Title: _____

Date: _____

Phone number: _____

ADDENDUM TO APPLICATION

Please answer the following questions. **If you answer "yes" to any of these questions, please explain on the reverse side of this sheet, or attach an additional 8 1/2" x 11" sheet(s) if necessary.**

	YES	NO
1. Are you certified by an American Specialty Board? (If yes, provide a notarized copy of all certificates).	_____	_____
2. Have you ever, for any reason, lost American Specialty Board Certification?	_____	_____
3. Have you been denied required recertification by any specialty boards? (If yes, list each boards and dates denied).	_____	_____
4. Has any medical malpractice suit been brought against you or has any claim been settled on your behalf in the last ten years? (If so, indicate how many).	_____	_____
5. Have you ever applied for licensure or to sit for an examination, or taken an examination, under a different name?	_____	_____
6. Have you ever been denied the privilege of taking or finishing an examination or been accused of cheating or improper conduct during an examination since you graduated from high school?	_____	_____
7. Have you ever failed any national medical licensure examination, or any part of that examination, state board examination or failed to gain certification from the National Board of Medical Examiners? **You must report all exam failures, even if you later passed the examination.** (This does not include specialty board certification examinations.)	_____	_____
8. Have you ever failed a foreign licensing or certification examination?	_____	_____
9. Have you ever been denied a medical license, whether full, limited or temporary, for any reason?	_____	_____
10. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, limited, suspended or revoked, or have you ever resigned from a medical staff in lieu of disciplinary action?	_____	_____
11. Is any investigation or disciplinary action pending, or has any investigation or disciplinary action been taken against you in the last ten years by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?	_____	_____

	YES	NO
12. Have you ever voluntarily surrendered a license to practice medicine or any healing art or allowed such a license to lapse in lieu of facing disciplinary investigation or action?	_____	_____
13. Have you ever been a defendant in a criminal proceeding including driving while under the influence or driving while suspended, which has not been annulled by a court, but not including traffic offenses not classified as misdemeanors or felonies?	_____	_____
14. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted or surrendered, or have you ever been charged, investigated or warned by a state or federal agency based on controlled substance issues?	_____	_____
15. Have you ever had any physical, emotional or mental illness which has impaired or would be likely to impair your ability to practice medicine?	_____	_____
16. Are you now, or have you, during the past 5 years, been dependent upon alcohol or habituating drugs or undergone treatment for such?	_____	_____

Anticipated Practice Location(s) (if known):

_____

_____

_____

_____ _____ _____

Applicant's Signature | Applicant's Printed Last Name | Date of Signature

For Board Use Only:

Application Received: _____, 20____ Fee Paid: _____ Check#: _____

License Number: _____ Date of Issue: _____

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Characteristics of the Car Title Lending Industry and its Customers in NH

Testimony Before The Commerce Committee
of the
NH House of Representatives

March 14, 2007

Brian Gottlob
PolEcon Research
Dover, NH 03820
bgottlob@poleconresearch.com

polecon research

To Understand the Industry and the Market for Title Loans we Empirically Examined:

- Characteristics of borrowers
- Characteristics of loans and lenders
- Alternatives to title lending to meet the demand among credit constrained households
- The economics of the industry (revenues, expenses, and earnings – current and under different regulations).

We are developing models of the economics of the industry that can presented to the Committee

Title Loan Customers in NH are More Likely to Be Credit Constrained Regardless of Income, Age Employment or Other Characteristics

polecon research

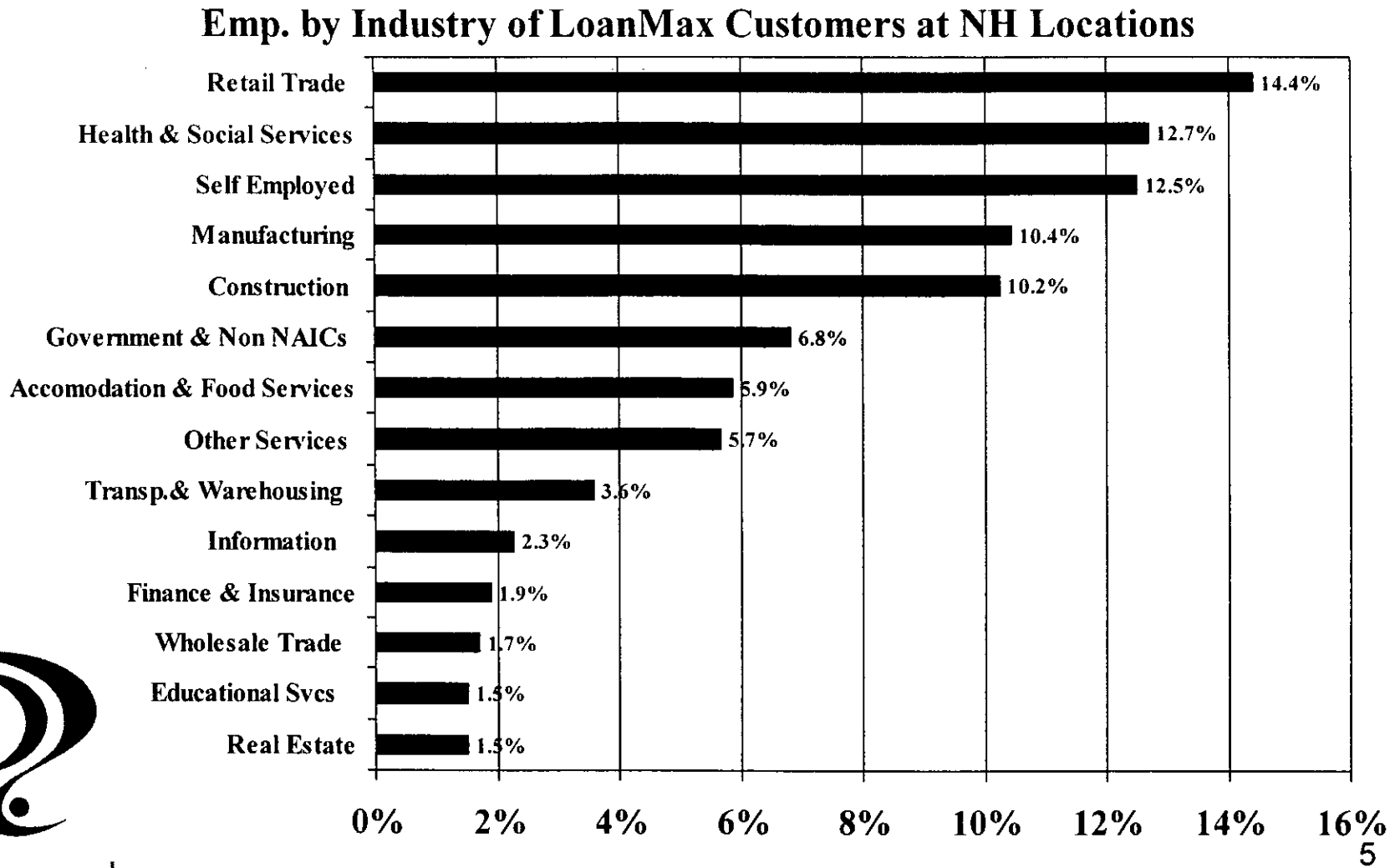
Overview of Customers at NH Locations

- Demographics show that borrowers come from all income levels, all industries and all occupations, indicating that:
- Credit "constraints" and the need for short-term loans cuts across economic, educational and other socioeconomic lines.

Title Loan Customers in NH:

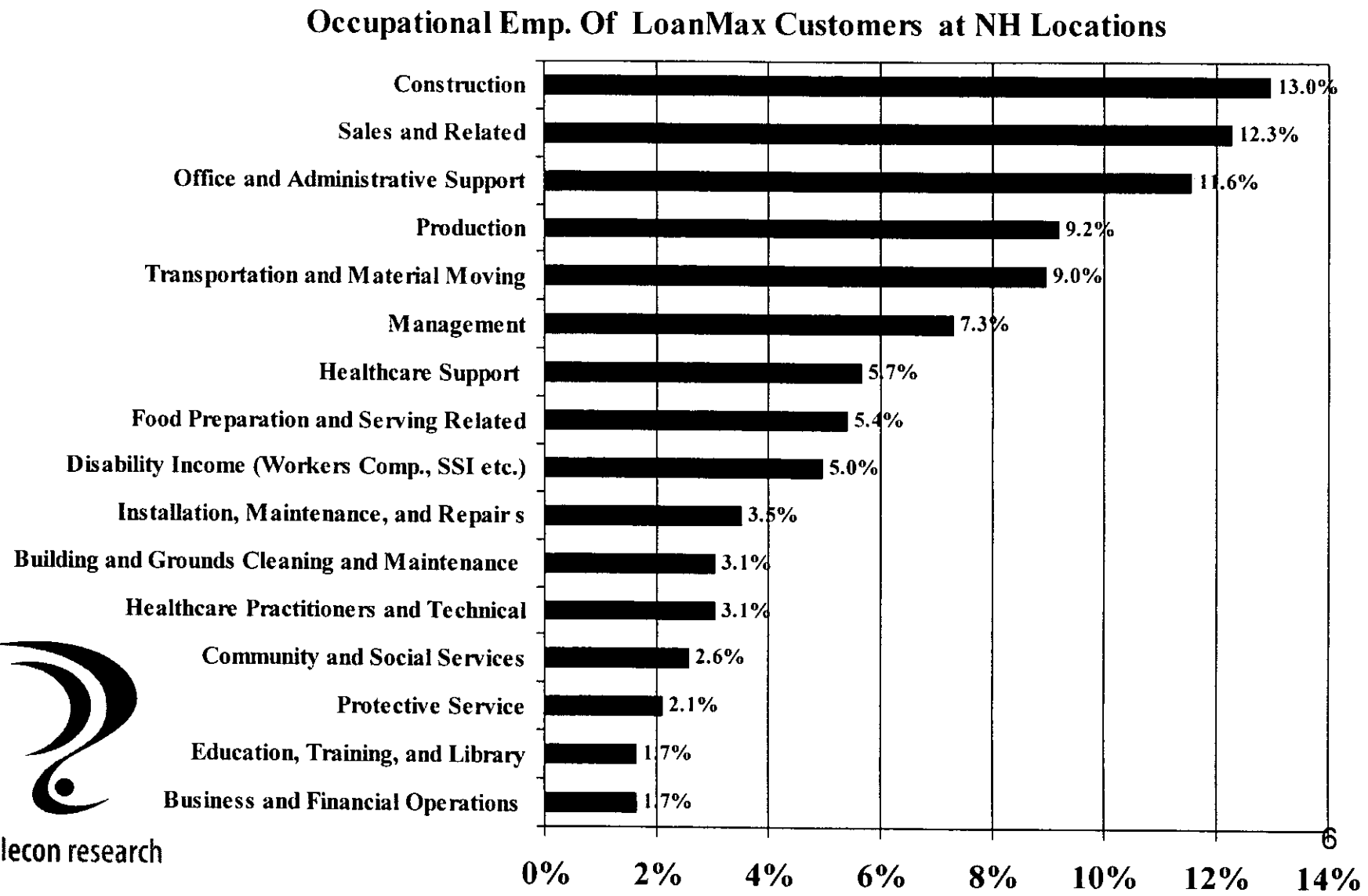
- Are employed
- Most are middle-aged
- Average income about $40,300 (Median about $40,000)
- Less likely to own a home and those that do…
- Are more likely to have a higher interest rate mortgage
- Both suggest customers are credit impaired and/or credit constrained

Workers in all Industries Can Be "Credit Constrained" and Have Short-Term Credit Needs That are Not Being Met by Other Institutions



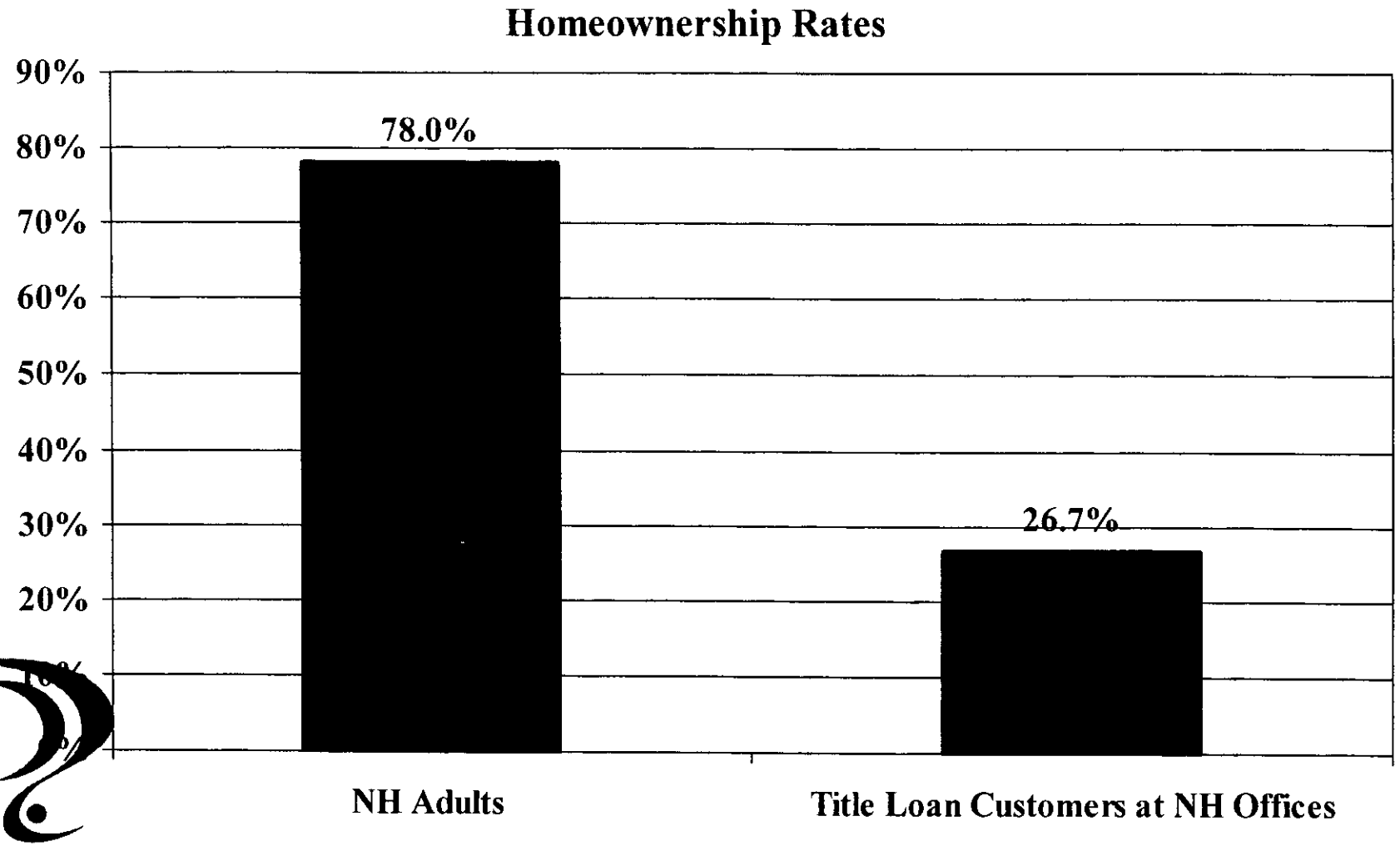
polecon research

All Occupations Use Title Loans but Those More Subject to Income Swings (Construction and Commission Sales Workers, Truck Drivers etc.) are More Likely to be Title Loan Customers



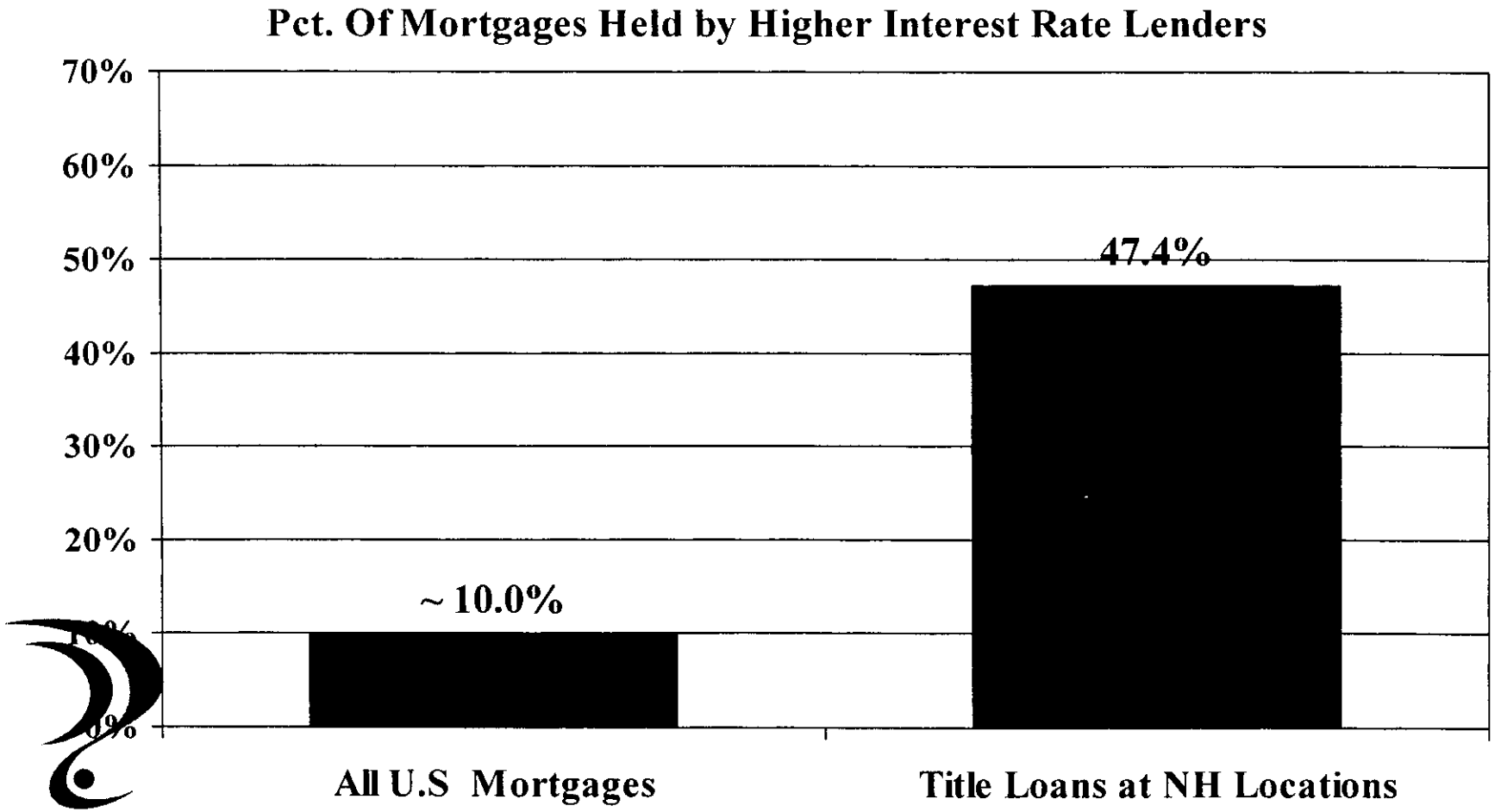
polecon research

Title Loan Borrowers Have Fewer Assets to Borrow Against: One-Third as Likely to be Homeowners



polecon research

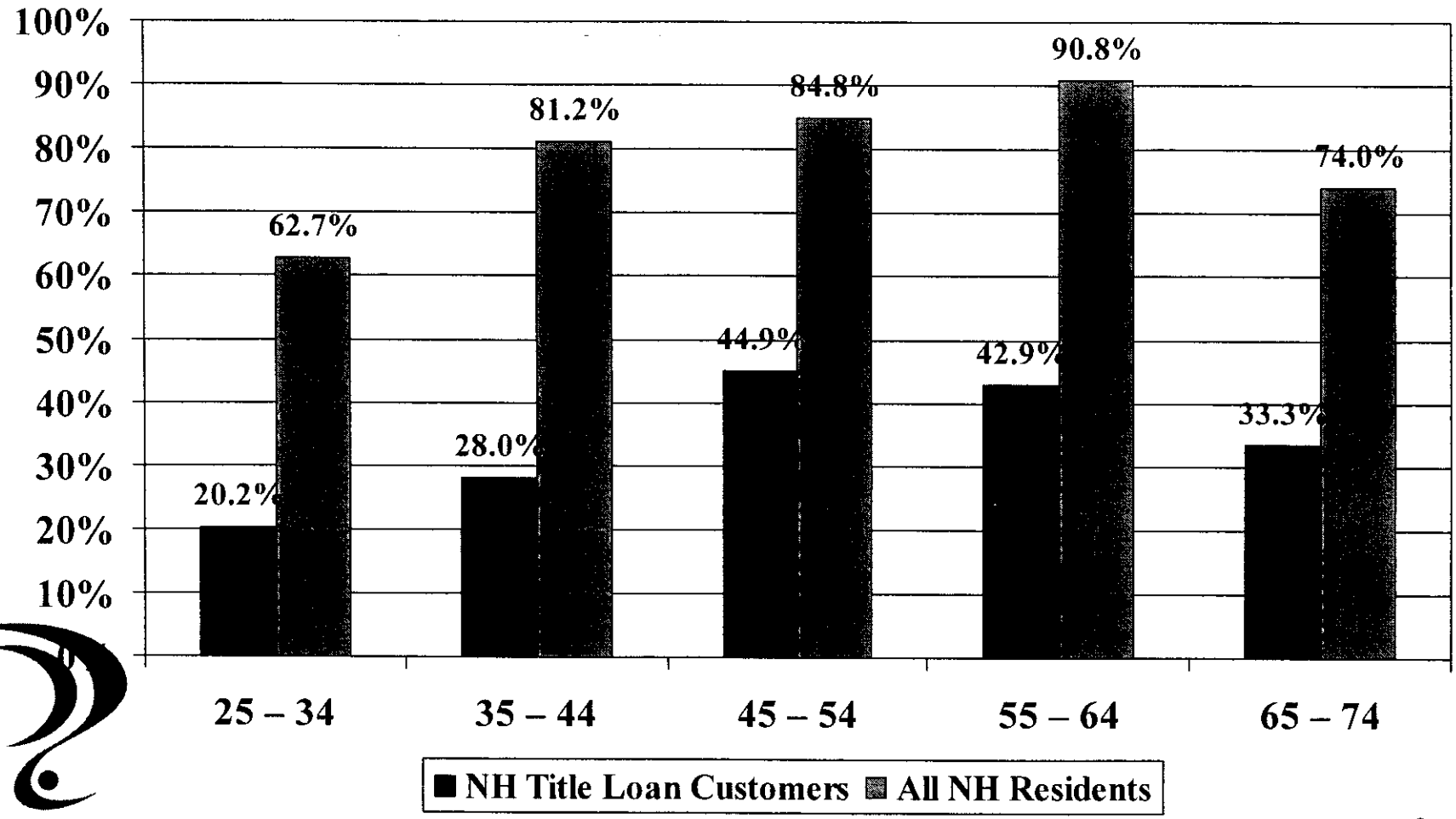
Homeowners who use title loans are more likely to have higher interest mortgages than the general US population, suggesting a greater likelihood of credit impairment. However, over half of homeowners who use title loans do NOT have higher interest mortgages suggesting these "homeowner" borrowers may choose title loans when other options are available



polecon research

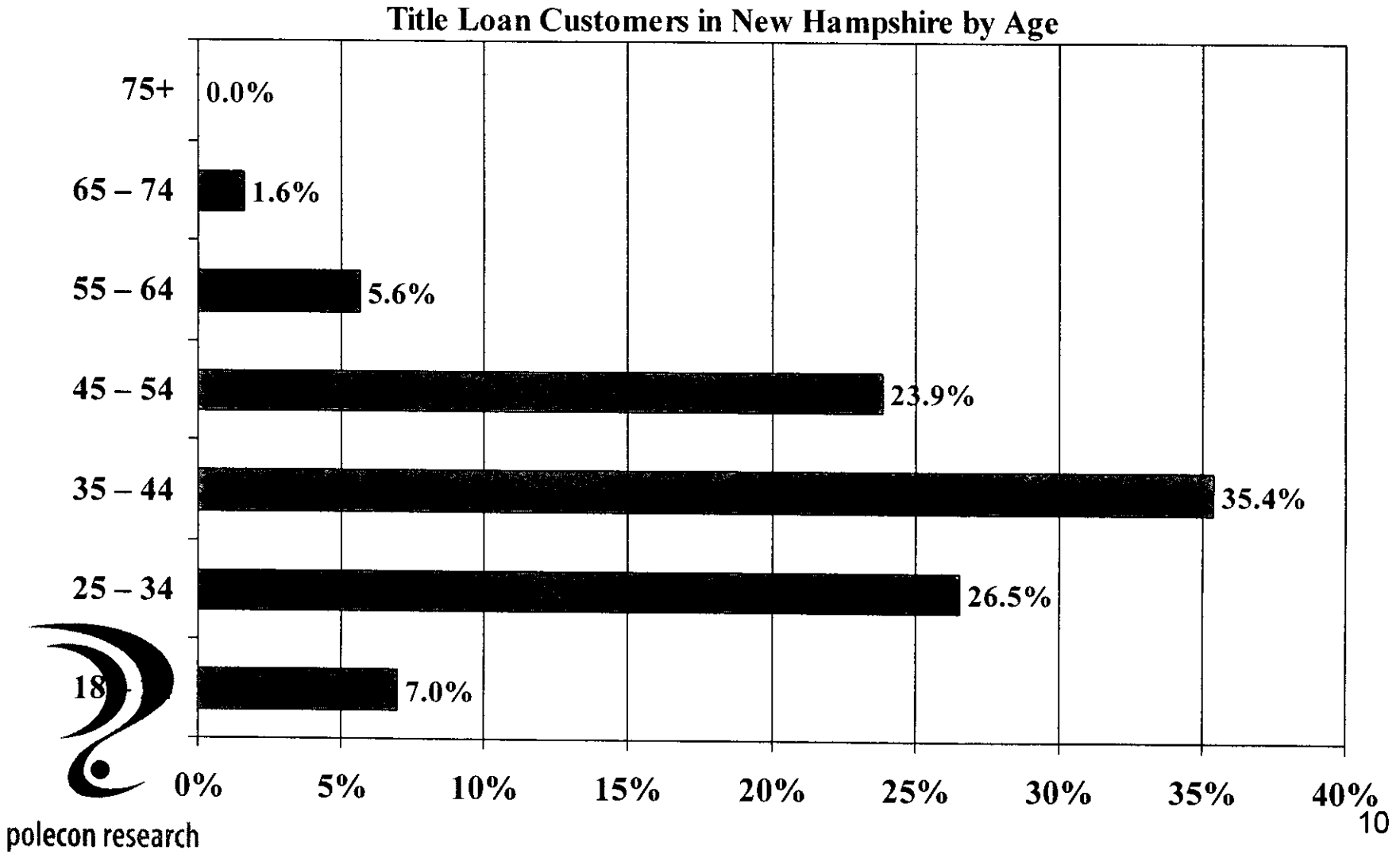
Homeownership Rates of Title Loan Customers are Lower at all Ages, and at all Income Levels

(Demonstrating That Credit Constraints or Credit Impairment Affects all Income and Age Groups)



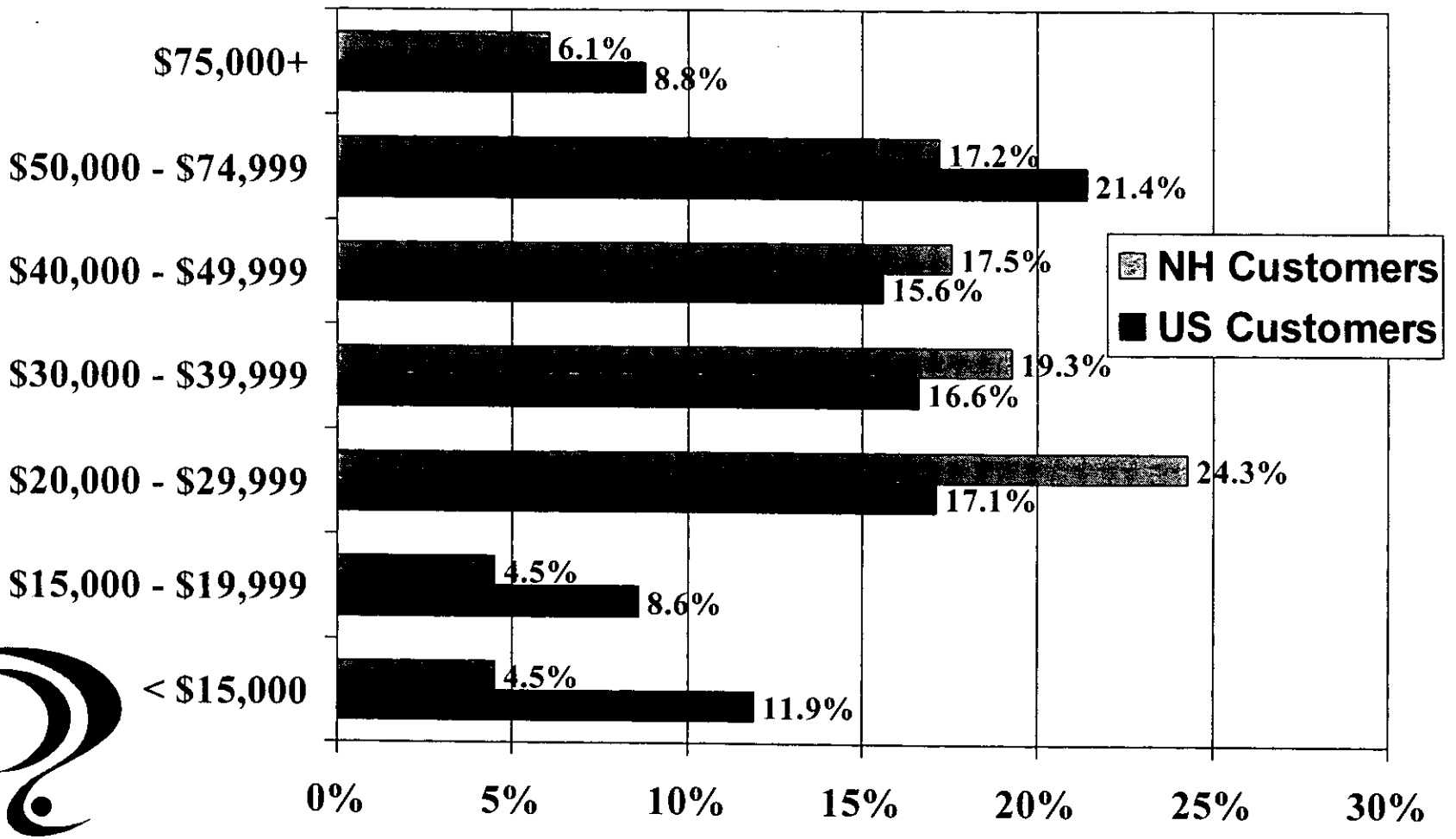
polecon research

Median Age of Borrowers in NH is 40 and NH has Few Older Borrowers



polecon research

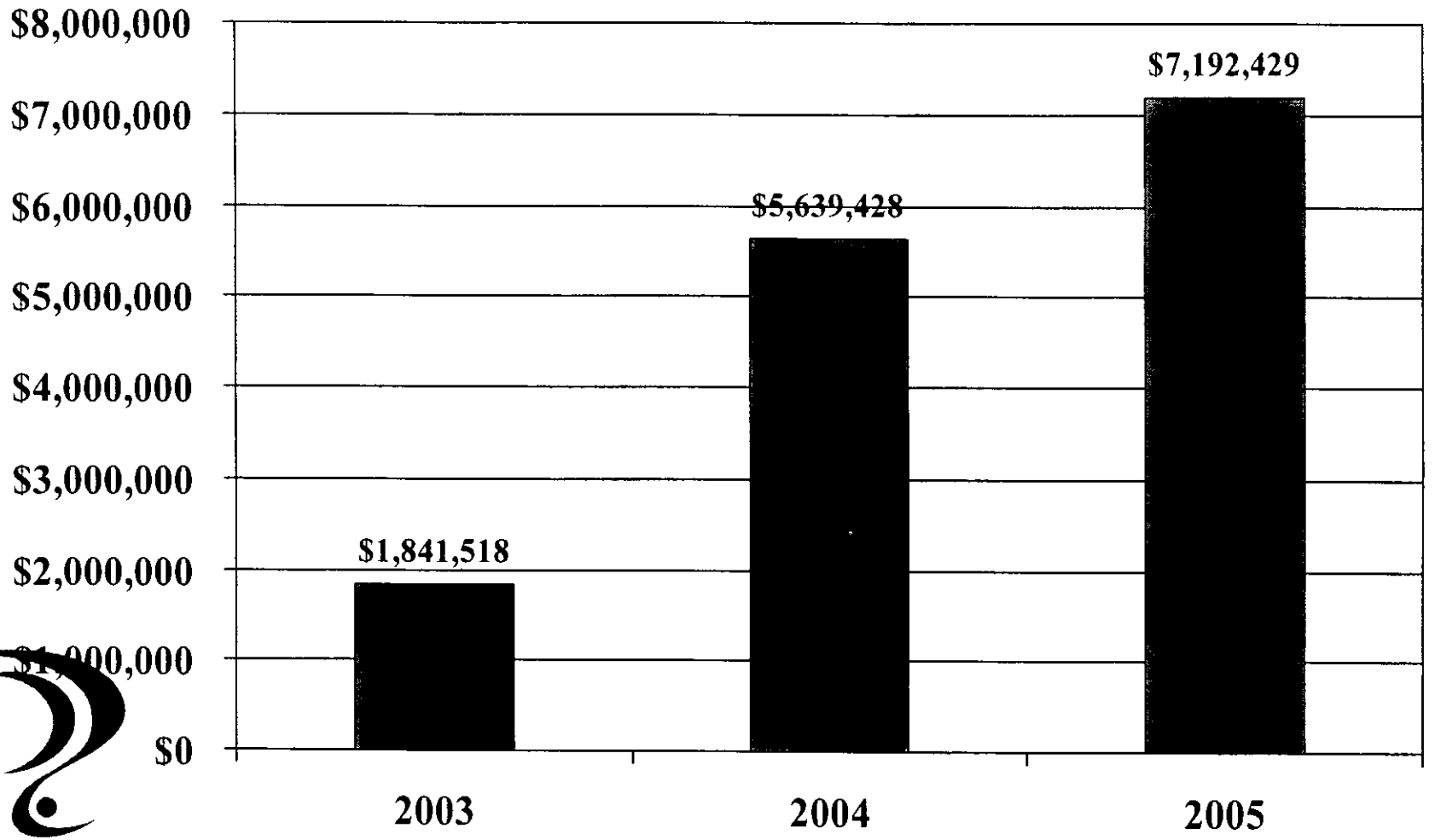
Customers at NH's Locations are Less Likely than U.S. Customers to be Low or Higher Income



polecon research

Volume of Title Loans in NH Has Been Rising

(But Compared to Payday Lending it is Quite Small)



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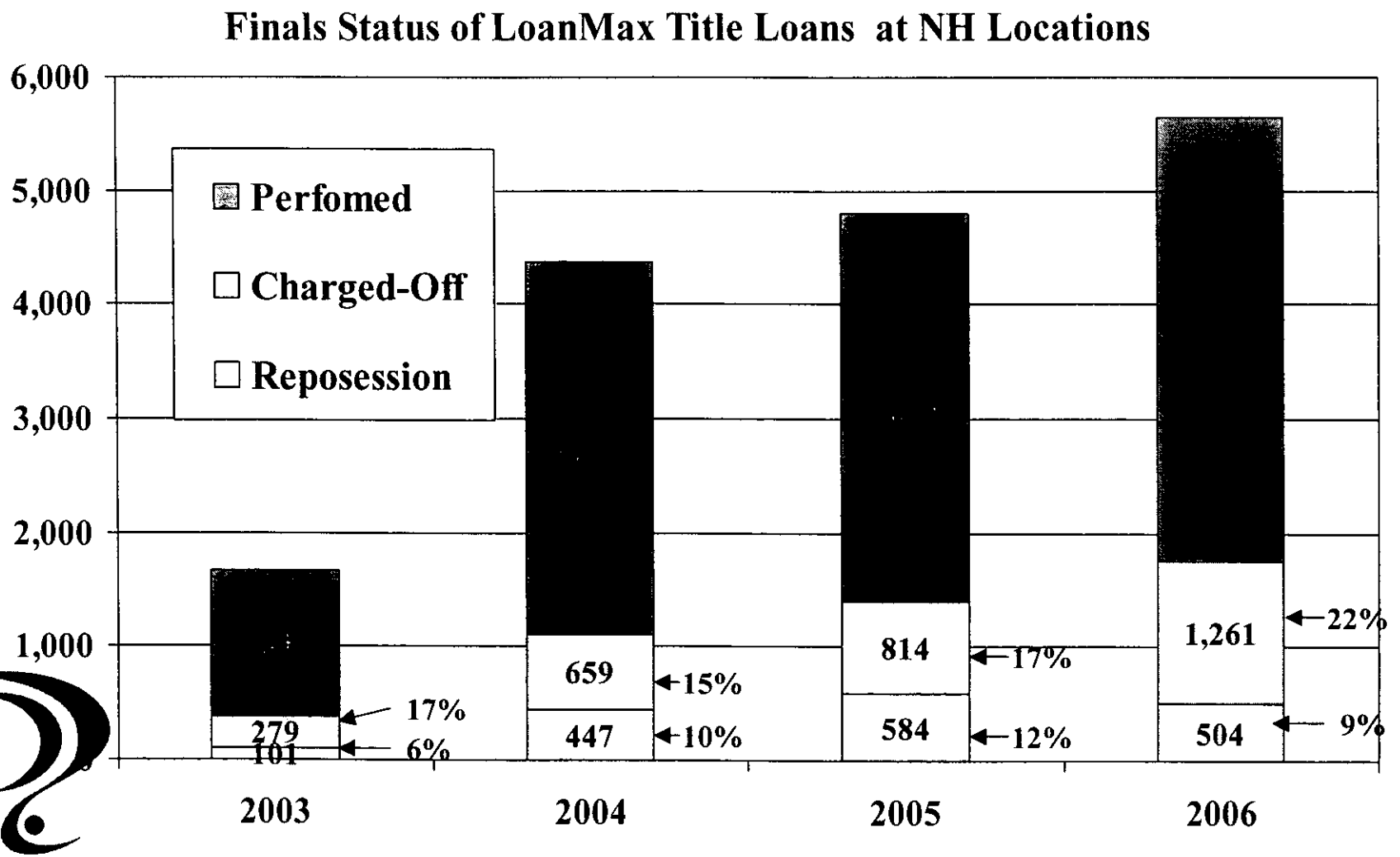
Demand is Clearly Rising, and so are Default Rates that are 30% at NH Locations



polecon research

Alternatives to Title Loans

- Not 'charity" or public assistance because borrowers are employed and incomes generally too high
- Banks – the cost of processing small loans makes them "uneconomic" and few banks offer
- Credit card and other credit – most customers are 'credit impaired" or "credit constrained"
- Few assets to borrow against

polecon research

Conclusions

- There is strong and growing need for short-term credit in NH
- Customers are diverse and come from all income and occupational groups
- Most are "credit constrained" or "credit impaired"
- Other institutions do not have products to meet demand
- A 36% rate cap results in large losses and will eliminate the industry in NH. Studies conducted by regulators in other states come to the same conclusion (the economics of the title loan industry and models can be presented and demonstrated at a future Committee meeting)
- *Empirical* studies by academic and government economists increasingly question the common perceptions of the industry

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Federation of
STATE
MEDICAL
BOARDS

Federation Credentials Verification Service (FCVS)

Instructions Applications and Forms for U.S./Canadian Medical School Graduates

Version 3.5D(u)

The Federation Credentials Verification Service is a division of the Federation of State Medical Boards of the United States, Inc.

General Information

The Federation Credentials Verification Service (FCVS) is operated by the Federation of State Medical Boards of the United States, Inc. (Federation), a national nonprofit organization that provides services for state medical and osteopathic licensing authorities in the U.S., Guam, Puerto Rico and the Virgin Islands. Its primary purpose is to provide a centralized, uniform and secure process for state licensing authorities—as well as private, governmental and commercial entities—to obtain a verified, primary source record of a physician's "core" credentials.

By using FCVS to verify your credentials, you will establish a permanent repository of primary source-verified documents. Once your file is established, these documents will be available for your use at any time. The documents that FCVS verifies for you fall into the following categories:

- **Identity**
- **Medical Education**
- **Postgraduate Training**
- **Examination History (state licensing authorities only)**
- **Board Action / Disciplinary History**
- **ABMS Certification**

Note:
Currently, FCVS does not verify state licensure or controlled substances registration. The information you provide is being stored for potential future verification.

Based on the verification of the above, a "Physician Information Profile" (Profile) is compiled and forwarded to the entity you specify in your application. FCVS will forward your Profile to any entity of your choice, including, but not limited to: state licensing authorities, hospitals, employers and professional memberships. The most recent list of accepting state licensing authorities is available by calling 1-888-ASK-FCVS, or via the Internet at www.fsmb.org.

The enclosed application is designed specifically for initial verification of your credentials. If you have previously established your repository of credentials with FCVS and wish to forward those credentials to another entity, you must obtain a "Subsequent Request" Application. Do not use the enclosed initial application for subsequent requests. You may complete a Subsequent Request Application online by going to our website at www.fsmb.org. [Note: Your state licensing authority will likely have its own application for licensure that is separate from the FCVS application. Applications for licensing authorities received at FCVS will be promptly returned.]

Note: FCVS does not issue medical licenses. This function is performed only by state licensing authorities. Furthermore, licensing authorities will require verification of other information and credentials you possess in addition to those verified by FCVS.

Glossary of Acronyms Used Within the Application

ECFMG: Educational Commission for Foreign Medical Graduates
FCVS: Federation Credentials Verification Service
LMCC: Licentiate of the Medical Council of Canada
NBME: National Board of Medical Examiners
NBOME: National Board of Osteopathic Medical Examiners
FLEX: Federation Licensing Examination
SPEX: Special Purpose Examination
USMLE: United States Medical Licensing Examination

Instructions for Completing the FCVS Application

Read these instructions and those throughout the application packet carefully before completing the application. **We will not begin the verification of your credentials until you submit all required information and appropriate documentation.** All of the information provided herein is subject to change.

I. General Instructions

Please refer to the following instructions before completing the FCVS Application:

1. The FCVS application is also available online at http://fcvs.fsmb.org.
2. Make a copy of the application before you begin should you make a mistake.
3. Type your information or print in black ball-point pen. FCVS will not interpret or make assumptions about the information you report in your application. Illegible information may result in processing delays.
4. Provide a response to each piece of information in the application packet. Items that are not applicable should be marked with an "N/A," for Not Applicable. You will be required to clarify, in writing, any items that are left blank on the application.
5. Include all components of the requested information, especially complete names and addresses of institutions
6. Failure to submit full addresses may result in delays.
7. To avoid delays and misidentification, double-check spelling and accuracy of the information you provide.
8. Print your full last name at the top of each page of the application form in the space provided.
9. For reference, make a copy of your completed application before you send it to FCVS.

II. Toll-free Customer Support Line

FCVS' toll-free customer support line is staffed Monday–Friday, 8:00 a.m.– 5:00 p.m., CST. Support personnel are prepared to answer questions about how to complete the FCVS application, as well as to provide general status of your application once received. "General status" is defined as confirmation of whether or not a specific document and/or verification has been received by FCVS. Further specific information about your packet is not available until after 60 days from the date FCVS receives your application. Please have your Packet ID Number available when you call.

All information concerning your FCVS file is considered highly confidential. If you desire to have a third party inquire about the status of your application (e.g., credentialing organization or office staff), you must designate this individual in Section 12 of your FCVS Application. FCVS will NOT discuss your file with any other individual(s) without your written consent.
You may contact FCVS at the following toll-free number:

1–888–ASK–FCVS
(1–888–275–3287)

III. Completing the Application

Most instructions for completing the FCVS application are located in the left column of the application; however, you should carefully read each of the following sections to avoid common mistakes. Please complete all components of the application that are applicable to you. **Do not estimate dates. If you are unsure about dates, please respond with "Unknown."**
Note: If the information obtained from the primary source differs from what you provide in your application, you may be required to clarify such discrepancies in writing. For purposes of documentation, all correspondence used to clarify discrepancies will be provided to the medical board from which you are seeking licensure.

Power-of-Attorney Not Acceptable: Physicians may not authorize a third party to sign FCVS documents on their behalf. Since FCVS processes Physician Profiles on a national basis and a Power-of-Attorney is a state-based instrument, a Power-of-Attorney will not be acceptable. Additionally, the confidential nature of documents and state board regulations requires the original signature of the physician.

IV. Completing the Required Forms

All of the following forms are critical to begin processing your application. Please be sure that each element of the forms is completed as required; otherwise, you will be required to complete an entirely new form.

Affidavit and Release, and Authorization for Release of Information

Complete this form and sign it in the presence of a notary. Attach a recent (less than six months) 2" x 2" passport quality color photograph of yourself (alone) to this form in the designated space. Photographs must be clear, front view, full face without a hat or dark glasses. Full-length photos, black and white or computer-generated photographs will not be accepted. Sign your name across the front of the photograph. Do not sign on the back of the photograph. Be certain that the notary follows the directions listed on the form.

NBME Examination History Release (if applicable)

Complete this form if you have ever taken any or all "Parts" of the National Board of Medical Examiners (NBME) examination (i.e., Parts I, II or III). This form will be included with FCVS' request for your NBME score transcripts. If you do not know your NBME Identification Number, write "unknown" in the required space. NBME will be able to process your request based upon the biographic information you provide on the form. Please do not call NBME to request your Identification Number. NBME has requested that you provide your current address in the space provided (optional) in order to update their database.

V. Required Documents

The following documents must be submitted with your FCVS application. Omitted documentation will result in processing delays.

Certified Birth Certificate or Current Original Passport

You must submit an original certified birth certificate (obtained directly from the issuing agency). If you submit a passport, you must include a valid written explanation as to why your birth certificate is not available. Be certain that your passport is signed. Unsigned, cancelled or expired passports will not be accepted.

Photocopies (including notarized photocopies) will not be accepted. Certified birth certificates must bear an official seal (or stamp) and a signature of an authorized representative of the issuing agency. Passports will be photocopied (identity section only) and promptly returned to your mailing address via priority mail, which requires a physical address, not a P.O. Box number. Applicants with return addresses outside the U.S. must make special mailing arrangements to have their passports returned. Typically, passports are copied and mailed within seven to ten business days. **Certified birth certificates become a permanent part of your file and will not be returned.**

Photocopy of Medical School Diploma

You must submit a legible 8½ x 11 photocopy of your medical school diploma with your application. Please include a copy of the back of the diploma if it displays text or seals. Photocopies that are larger than 8½ x 11 will not be accepted. Diplomas must clearly display the following:

1. The name of the institution
2. The institution's official seal (or stamp) and a signature of an authorized representative
3. Your name
4. The degree awarded
5. The date degree was awarded

Documentation of Use of Alternate Name

You are required to document all Alternate Names (i.e., any name that you have used in the past). To do this, you must: 1) submit a certified copy of the legal document which explains the use of such name (e.g., marriage certificate, name change documents, etc.), or 2) for alternate names not explained with legal documents, provide a written explanation of the use of such name. If you choose option #2, you must use the Explanation of Alternate Name Form (enclosed). This explanation will be included in your Profile.

Residency Training Certificates

FCVS recommends that you submit photocopies of your internship/residency training or fellowship certificates to assist in the verification process of your training performed in the United States.

VI. Fees

Please follow these instructions to complete the "Fee Calculation" section of the application. To avoid processing delays due to incorrect fees, please call FCVS' toll-free customer support line. Credentials Inquiry Specialists will assist you with calculating your fees.

A. Initial Application Processing Fee

The base processing fee to establish your initial FCVS Profile is **$295, with an additional $50 fee for applications not submitted online.** This fee entitles you to have your Profile sent to one recipient. In addition to the base fee, other applicable "surcharges" may apply. Surcharges are assessed for Examination Score Transcripts (section C), passport shipping and handling (section E) and administrative verification fees from institutions.

B. Additional Profile Requests

Additional Profiles may be forwarded for a fee of **$60** for **each** additional mailing, plus applicable surcharges when ordered with the initial Profile. To forward additional Profiles after your initial application has been mailed, you must complete a separate Subsequent Request Application. You may complete a Subsequent Request Application online by going to our website at www.fsmb.org.

C. Examination Score Transcripts

Each organization that provides FCVS with examination history (transcripts) has a unique fee structure. Please review the following instructions carefully. **Do not request transcripts on your own behalf. FCVS will not accept, substitute, or waive surcharges for any transcript requested by applicants.** Transcripts are required for state licensing authorities only. Do not include transcript surcharges for other entities (i.e., hospitals, medical societies).

1. USMLE Steps 1, 2 and 3 FLEX Component 1 and 2
Pre-1985 FLEX SPEX

The Federation issues an examination history report which includes all of the above examinations. The fee for this transcript (which includes a complete report of all of the above examinations, including failing attempts) is $50 for one to two transcripts. Note: FCVS does not store these transcripts. You must submit the appropriate fee for each Profile being forwarded.

Those who have taken a USMLE "Step" in combination with an NBME "Part" should only submit surcharges for the NBME transcript (see NBME Part I,II and III below). The NBME transcript reports all USMLE Step history.

2. NBME Part I, II and III

FCVS obtains verification of your NBME examination history according to the requirements of the medical licensing authority(ies) where you are having your Physician Information Profile sent.

The NBME examination history is $50 for up to five (5) transcripts, and $5 for each additional transcript requested at the same time. Note: FCVS does not store NBME transcripts. You must submit the appropriate fee for each Profile being forwarded.

> **Note: Many applicants confuse NBME Parts with USMLE Steps. Please be certain to accurately report your examination history. Misreporting these examinations in your application will result in processing delays and additional surcharges.**

3. Licentiate of the Medical Council of Canada (LMCC)

The Medical Council of Canada (MCC) provides FCVS with a statement confirming your registration as a Licentiate of the Medical Council of Canada as well as the scores received on the Council's examinations. FCVS collects $95 to offset MCC fees (and exchange rates) for this service. FCVS has been given permission to store and reproduce this verification and therefore requires that you submit this fee only one time with your initial application.

4. State Board Examinations

Each medical licensing authority has a different fee for their respective examination transcript. If you have taken a state board examination, please call FCVS' toll-free number for the appropriate amount.

> **Note: State board examinations were developed and administered specifically by medical licensing authorities. Do not confuse these examinations with national licensing examinations such as the FLEX, NBME, NBOME or USMLE.**

D. Shipping and Handling

Applicants submitting a passport to verify identity must submit a $25 shipping and handling fee to cover charges incurred to return it via priority mail. Priority mail service does not deliver to a P.O. Box address. If your mailing address is a P.O. Box, you must make special arrangements for the return of your passport. Please call 1-888-ASK-FCVS to discuss mailing options.

Other Fee Information

Translation Fee

Any document(s), including birth certificates or passports, written in a language other than English that is received and/or verified by a primary source must be translated by FCVS' professional translation service. FCVS does not accept translations from any other source. FCVS will send you an invoice for the amount of the translation once the document requiring translation has been received. FCVS will add a one-time processing fee of $15 to all translation charges at the time of invoice.

Insufficient Funds

Checks returned for insufficient funds will be assessed a $25 fee after the check has been submitted for payment twice. Processing of your application will be suspended until a cashier's check or money order covering the original application fee plus the $25 fee is received.

Payment

Make your check or money order payable in U.S. dollars to Federation Credentials Verification Service. Do not send cash with your application.

Cancellation Policy

A significant portion of application processing occurs immediately after applications are received; therefore, requests for cancellations must be submitted in writing within five business days from the date FCVS receives your application. In all cases of cancellation, a $50 processing fee will be deducted. No refunds will be granted after five business days.

Recipient Designation Change Fee

If you change the recipient of your Profile while your application is still pending (including a change to "Undecided" status), you will be assessed a $15 change fee, plus applicable surcharges necessary to obtain new examination score transcripts (if necessary). Applications originally designated as "Undecided" are exempt from this fee. To change your recipient designation, contact our toll-free customer support line to receive a Recipient Designation Change Form, or download the form at the Federation's web site at www.fsmb.org.

Overpayment

FCVS will send you a letter notifying you of a credit balance (overpayment) on your account at the time your Profile is forwarded to all entities designated in your application. You must submit a written request (with address verification) to receive this refund. Overpayment of $50 or less remaining in an FCVS account after 30 months from the application receipt date will not be refunded.

Institutional Administrative Verification Fees

A one-time fee of $25 is required of all applicants for handling fees charged by Medical Schools and Postgraduate training programs for transcripts and verifications to FCVS/ECFMG.

VII. Submitting Your FCVS Application Materials

For submission to FCVS, please assemble and secure your application materials in the following order:

1. Check or Money Order (in the upper left-hand corner)
2. FCVS Application Pages 1-10 (do not omit pages, even if a page was not applicable to you)
3. Affidavit and Release and Authorization for Release of Information, Documents and Records
4. NBME Examination History Release (if applicable)
5. All Other Attachments except passport

All application materials except passports* must be mailed via standard U.S. Postal Service (Not Express, Certified or Overnight) to the P.O. box listed below. Application and/or checks received at the Federation's Fuller Wiser Road address will be delayed by at least five business days and will be assessed a $15.00 handling fee.

Federation Credentials Verification Service
P.O. Box 970900
Dallas, TX 75397-0900

To avoid delays and additional processing fees, do NOT send applications to the Federation's Fuller Wiser Road address. FCVS will send a letter to acknowledge receipt of your application after it is reviewed.

*** For security reasons FCVS suggests all passports be sent to the physical mailing address listed below using FedEx or DHL/Airborne Express only, which will require a signature upon delivery. The address is — 400 Fuller Wiser Road, Suite 300, Euless, TX 76039-3855.**

VIII. Processing Your Application

Application Review and Processing

Upon receipt, your application is carefully inspected to ensure all documents, required forms and fees have been submitted in accordance with established requirements. If your application is deemed acceptable to process, FCVS will begin verification with your primary sources. If you omit any required information, documents or fees, you will be required to resolve and/or supply each outstanding component. In some cases, processing may be suspended until all requirements are satisfied.

Very Important: Any omitted information or documentation will cause significant delays in the time to process your profile.

For documentation purposes, all clarification of problems and/or subsequent submissions must be submitted in writing. FCVS cannot record information into the database without written documentation.

"Undecided" Applicants

The "Undecided" category (see Application, Section 21) is designed to accommodate those physicians who wish to begin the process of establishing their core credentials but have not yet designated an entity to receive their Profile. "Undecided" applications will be fully processed except for the examination score transcript. Once you designate a recipient of your Profile, FCVS will order the above mentioned documents.

Verification with Primary Sources

The information you provide in your application is used by FCVS to verify your credentials. To verify the information you provide, FCVS sends a series of letters and special verification forms directly to the institutions you list in your application. FCVS must initiate all requests for primary source verification. Do not attempt to expedite the verification process by making these requests yourself. FCVS will not accept documents from primary sources requested by the physician. FCVS will not be responsible for any expenses incurred by applicants who make verification requests on their own behalf.

Quality Assurance

All Physician Information Profiles are subjected to a comprehensive audit process to ensure accurate and complete reporting. At this stage, each data element of your application is compared to each data element received from the primary source. Discrepant information may require additional follow-up for clarity.

Physician Information Profile Forwarded

FCVS mails Profiles via overnight service to entities designated in your application. FCVS will send you a letter informing you that your Profile has been sent. FCVS does not provide photocopies of Profiles to applicants. If you wish to review your Profile, you must contact the entity that received your Profile, or submit payment for a Subsequent Request with yourself as the recipient.

IX. Time Expectations to Process Your Application

The majority of processing time is dependent upon the timely and accurate responses of other institutions. Because of this, FCVS cannot guarantee that your file will be processed within a specific time frame. FCVS processes applications as quickly as possible in the order they are received and will not—under any circumstances—expedite processing of one file over the other.

FCVS has found that processing time ranges from eight to twelve weeks from the date of receipt of complete documentation from you, depending on the complexity of your file. Individual processing time will vary. We will not begin the verification of your credentials until you submit all required information and appropriate documentation. Those who submit applications between February 1st and June 30th (peak processing period) should expect processing to be delayed by 2-3 weeks.

X. Common Questions About Application Processing

I need to start practicing very soon. Is there some way I can speed up this process?
The best way to expedite application processing is to make sure your application is 100% complete with all required information, documentation and fees before submitting it to FCVS. If your application is received without problems, FCVS can immediately begin verifying your credentials with your source institutions. In addition, you will improve response time from your sources if you provide precise, complete addresses.

I only have one certified birth certificate and don't want you to keep it. How do I get another one?
Any US born individual can obtain a certified birth certificate by contacting the Vital Statistics Bureau in their state of birth by telephone or via internet at www.vitalrec.com for a nominal fee. Any US citizen born overseas can obtain a certified copy of his/her birth certificate by contacting the US State Department. Please do not send birth certificates that are illegible or have sentimental value.

I am hesitant to send you my original passport. How safe is it?
FCVS has received and safely returned thousands of passports. For security reasons, FCVS suggests sending passports to the physical address—400 Fuller Wiser Road, suite 300, Euless, TX 76039-3855—using FedEx or DHL/Airborne Express only, which will require a signature upon delivery.

I called my institution, and they never received your request for verification. Will you send another one?
FCVS mails verification requests directly to the address listed on the ACGME (Accreditation Council for Graduate Medical Education) web site which is continually updated. FCVS will follow-up with nonresponsive U.S./Canadian institutions (generally by telephone) after 21 days.

How do I forward additional (Subsequent) Physician Information Profiles?
To have an additional Physician Information Profile forwarded to another entity of your choice, you must complete a Subsequent Request application. To download the full version from the internet, visit our Web site at www.fsmb.org. This application will instruct you how to complete the required forms and help you calculate the appropriate fees. To receive this application by mail, call 1-888-ASK-FCVS, or send your request via e-mail at fcvs@fsmb.org (you must include your name, Packet ID Number and current address).

What state medical boards currently accept FCVS documents?
FCVS continues to add state medical boards to its roster of those that accept our documents. For the most current list, you can call 1-888-ASK-FCVS, or visit our web site at www.fsmb.org/acceptFCVSprofile.htm.

Federation of STATE MEDICAL BOARDS

Federation Credentials Verification Service

Application for credentials verification

Refer to the application instructions when completing these forms. Type or block print only. Do not use felt-tip pens.

1. Name(s)
Do not use nicknames or initials, unless they are part of your documented name.

Documentation:
See instructions (page 3): Documentation of use of Alternate Name.

Last Name (Surname) and Generational Suffix

First and Middle Name(s)

List any alternate name(s) you have used in the past (first, middle and last).

☐ I have not used any other name(s).

Last Name (Surname) and Generational Suffix

First and Middle Name(s)

2. Date and Place of Birth

Documentation:

You must submit a certified birth certificate. If you submit a passport, you must explain why your birth certificate is not available.

Month Day Year

City State

Province/Territory

Country

3. Identification Numbers

U.S. Social Security Number

National Identification Number (if applicable)

Issuing Country

4. Gender

☐ Male ☐ Female

Applicant: Print your complete last name: _____

5. Mailing Address

For communication regarding your FCVS application.

It is your responsibility to keep FCVS appraised of all address changes.

Address Line 1

Address Line 2

City | State

Country | ZIP/Postal Code

6. Permanent Address

If same as mailing, check here: ☐

Address Line 1

Address Line 2

City | State

Country | ZIP/Postal Code

7. Telephone Numbers

U.S./Canadian telephone numbers only.

Business Phone | Ext. | Business Fax

Home Phone | Other e.g. pager

8. E-mail Address(es)

List a primary and secondary e-mail address, if available.

Primary E-mail Address

Secondary E-mail Address (if available)

9. Physical Description

Height: ☐☐ Feet ☐☐ Inches Weight: ☐☐☐ Pounds

Eye Color: Hair Color:

Physical Marks:

☐ I have no physical marks.

☐ I have the following physical marks:

Description of mark | Location

Description of mark | Location

10. Third-party Authorization

Your FCVS file is confidential.

If you intend to have any person other than yourself communicate with FCVS about your application, you must complete this section.

☐ I will be the only individual to inquire about my FCVS application.

☐ I authorize the following individual to inquire about my FCVS application (see below).

Last Name (Surname) and Suffix

First Name

Telephone | E-mail

By completing this section, you authorize FCVS to discuss the status your FCVS application with the above-named individual. Specific information regarding qualitative aspects of your credentials (i.e. grades, examination scores, evaluations, etc) will not be released under any circumstances.

Applicant: Print your complete last name: _____

11. State Licensure

List all active and inactive or expired professional licenses you have held.

Active Licenses

State | Type | Number | Original date of issue | Expiration Date

State | Type | Number | Original date of issue | Expiration Date

State | Type | Number | Original date of issue | Expiration Date

Inactive or Expired Licenses

State | Type | Number | Original date of issue | Expiration Date

State | Type | Number | Original date of issue | Expiration Date

12. Specialty Certification

Please list your current certification status.

Include additional information on a separate 8.5" x 11" sheet of paper.

Specialty _____

Board Certified? Yes ☐ No ☐ If no, are you qualified to sit for the exam? Yes ☐ No ☐

Board name _____

Initial certification date _____ Date of most recent certification _____

Date qualified _____ Qualification expires _____

(Sub)Specialty _____

Board Certified? Yes ☐ No ☐ If no, are you qualified to sit for the exam? Yes ☐ No ☐

Board name _____

Initial certification date _____ Date of most recent certification _____

Date qualified _____ Qualification expires _____

(Sub)Specialty _____

Board Certified? Yes ☐ No ☐ If no, are you qualified to sit for the exam? Yes ☐ No ☐

Board name _____

Initial certification date _____ Date of most recent certification _____

Date qualified _____ Qualification expires _____

13. Controlled Substance Registration

List your current DEA and State Registration Number(s)

Include additional information on a separate 8.5" x 11" sheet of paper.

Federal DEA number | Date issued | Expiration date

State controlled substances registration number | Date issued | Expiration date | State

State controlled substances registration number | Date issued | Expiration date | State

State controlled substances registration number | Date issued | Expiration date | State

14. Premedical Undergraduate Education

List all colleges/universities you attended prior to medical school in chronological order.

If a break of six (6) months or more occurred during the attendance dates you provide, report the beginning and ending dates of this break on a separate 8.5" x 11" sheet of paper. It is not necessary to report breaks between institutions.

Combined M.D./Ph.D. programs should be reported in Section 17 U.S./Canadian Medical Education.

Note:
FCVS does not verify premedical education (except in cases where credit was granted towards the medical degree). The information you provide will be reported exactly as it appears on this page.

Name of institution #1

Address

City State

Country ZIP/Postal Code

Degree ☐ None ☐ B.A. ☐ B.S. ☐ M.A. ☐ M.S. ☐ Other_____

From Month Year To Month Year

Name of institution #2

Address

City State

Country ZIP/Postal Code

Degree ☐ None ☐ B.A. ☐ B.S. ☐ M.A. ☐ M.S. ☐ Other_____

From Month Year To Month Year

Name of institution #3

Address

City State

Country ZIP/Postal Code

Degree ☐ None ☐ B.A. ☐ B.S. ☐ M.A. ☐ M.S. ☐ Other_____

From Month Year To Month Year

Name of institution #4

Address

City State

Country ZIP/Postal Code

Degree ☐ None ☐ B.A. ☐ B.S. ☐ M.A. ☐ M.S. ☐ Other

From Month Year To Month Year

15. U.S/ Canadian Medical Education

List all the medical schools you attended in chronological order.

You may photocopy this page to report more than two institutions if necessary.

If necessary, you may continue your explanation of Unusual Circumstances on a separate 8.5" x 11" sheet of paper. Your response may not exceed 100 words per question.

DOCUMENTATION: You must include a complete, legible photocopy of your medical school diploma.

If a break of six months or more occurred between medical schools attended or between graduation from medical school and your first year PGT, please provide a written explanation outlining your activities during this "gap" period on the enclosed Gap Explanation Form.

Complete name of institution #1 (Do not abbreviate)

City State

From: To: Degree

☐ None ☐ M.D. ☐ D.O.
☐ M.D./Ph.D. combined
☐ Did not graduate
☐ B.A./M.D. combined

Date Degree was conferred/issued:

Month Day Year

Unusual Circumstances (circle yes or no):

Did you have any interruption(s) or extension(s) in your medical education? ☐ Yes ☐ No

Were you ever placed on probation? ☐ Yes ☐ No

Were you ever disciplined or placed under investigation? ☐ Yes ☐ No

Were any negative reports ever filed against you? ☐ Yes ☐ No

Were any limitations or special requirements imposed on you because of academic, incompetence, disciplinary problems or for any other reason? ☐ Yes ☐ No

Please explain any "Yes" responses from above: _____

Complete name of institution #2 (do not abbreviate)

City State

From: To: Degree

☐ None ☐ M.D. ☐ D.O.
☐ M.D./Ph.D. combined
☐ Did not graduate
☐ B.A./M.D. combined

Date Degree was conferred/issued:

Month Day Year

Unusual Circumstances (circle yes or no):

Did you have any interruption(s) or extension(s) in your medical education? ☐ Yes ☐ No

Were you ever placed on probation? ☐ Yes ☐ No

Were you ever disciplined or placed under investigation? ☐ Yes ☐ No

Were any negative reports ever filed against you? ☐ Yes ☐ No

Were any limitations or special requirements imposed on you because of academic, incompetence, disciplinary problems or for any other reason? ☐ Yes ☐ No

Please explain any "Yes" responses from above: _____

16. Postgraduate Medical Education

List all of the postgraduate medical education programs you attended in chronological order. Use one page per institution. You are provided two pages (p. 7 - 8) in this application to report this information. You must make a photocopy(ies) of this page to report more than two institutions.

IMPORTANT: Report incomplete postgraduate years (PGY) separate from those that were successfully completed. If your postgraduate year is currently in progress, indicate the expected completion date in the "To" field. Report internships, residencies, fellowships and research programs separately.

Use one section per department.

(PGY) - Postgraduate years is also known as postgraduate training level.

If a break of six months or more occurred between any of your postgraduate training activities, please provide a written explanation outlining your activities during this "gap" period on the enclosed Gap Explanation Form.

Please submit photocopies of your internship/residency training or fellowship certificates.

If necessary, you may continue your explanation of Unusual Circumstances on a separate 8.5" x 11" sheet of paper. Your response may not exceed 100 words per question.

Complete name of hospital where training was conducted (Do not abbreviate).

Complete name of affiliated university or college (Do not abbreviate).

Address line 1

Address line 2

City State

Country ZIP/Postal Code

PGY: ____
- ☐ Internship
- ☐ Residency
- ☐ Chief Resident
- ☐ Fellowship
- ☐ Research

Specialty/Subspecialty

From: Month Year To: Month Year

Successfully completed? ☐ Yes ☐ No ☐ In progress

PGY: ____
- ☐ Internship
- ☐ Residency
- ☐ Chief Resident
- ☐ Fellowship
- ☐ Research

Specialty/Subspecialty

From: Month Year To: Month Year

Successfully completed? ☐ Yes ☐ No ☐ In progress

PGY: ____
- ☐ Internship
- ☐ Residency
- ☐ Chief Resident
- ☐ Fellowship
- ☐ Research

Specialty/Subspecialty

From: Month Year To: Month Year

Successfully completed? ☐ Yes ☐ No ☐ In progress

PGY: ____
- ☐ Internship
- ☐ Residency
- ☐ Chief Resident
- ☐ Fellowship
- ☐ Research

Specialty/Subspecialty

From: Month Year To: Month Year

Successfully completed? ☐ Yes ☐ No ☐ In progress

Unusual Circumstances (circle yes or no):

Did you ever take a leave(s) of absence or break(s) from your medical education?	☐ Yes	☐ No
Were you ever placed on probation?	☐ Yes	☐ No
Were you ever disciplined or placed under investigation?	☐ Yes	☐ No
Were any negative reports ever filed against you?	☐ Yes	☐ No
Were any limitations or special requirements imposed on you because of academic, incompetence, disciplinary problems or for any other reason?	☐ Yes	☐ No

Please explain any "Yes" responses from above:

____

____

Applicant: Print your complete last name: ______________________

16. Postgraduate Medical Education

List all of the postgraduate medical education programs you attended in chronological order. Use one page per institution. You are provided two pages (p. 7 - 8) in this application to report this information. You must make a photocopy(ies) of this page to report more than two institutions.

IMPORTANT: Report incomplete postgraduate years (PGY) separate from those that were successfully completed. If your postgraduate year is currently in progress, indicate the expected completion date in the "To" field. Report internships, residencies, fellowships and research programs separately.

Use one section per department.

(PGY) - Postgraduate years is also known as postgraduate training level.

If a break of six months or more occurred between any of your postgraduate training activities, please provide a written explanation outlining your activities during this "gap" period on the enclosed Gap Explanation Form.

Please submit photocopies of your internship/residency training or fellowship certificates.

If necessary, you may continue your explanation of Unusual Circumstances on a separate 8.5" x 11" sheet of paper. Your response may not exceed 100 words per question.

Complete name of hospital where training was conducted (Do not abbreviate).

Complete name of affiliated university or college (Do not abbreviate).

Address line 1

Address line 2

City | State

Country | ZIP/Postal Code

PGY: ______
- ☐ Internship
- ☐ Residency
- ☐ Chief Resident
- ☐ Fellowship
- ☐ Research

Specialty/Subspecialty

From: Month Year | To: Month Year | Successfully completed? ☐ Yes ☐ No ☐ In progress

PGY: ______
- ☐ Internship
- ☐ Residency
- ☐ Chief Resident
- ☐ Fellowship
- ☐ Research

Specialty/Subspecialty

From: Month Year | To: Month Year | Successfully completed? ☐ Yes ☐ No ☐ In progress

PGY: ______
- ☐ Internship
- ☐ Residency
- ☐ Chief Resident
- ☐ Fellowship
- ☐ Research

Specialty/Subspecialty

From: Month Year | To: Month Year | Successfully completed? ☐ Yes ☐ No ☐ In progress

PGY: ______
- ☐ Internship
- ☐ Residency
- ☐ Chief Resident
- ☐ Fellowship
- ☐ Research

Specialty/Subspecialty

From: Month Year | To: Month Year | Successfully completed? ☐ Yes ☐ No ☐ In progress

Unusual Circumstances (circle yes or no):

Did you ever take a leave(s) of absence or break(s) from your medical education?	☐ Yes	☐ No
Were you ever placed on probation?	☐ Yes	☐ No
Were you ever disciplined or placed under investigation?	☐ Yes	☐ No
Were any negative reports ever filed against you?	☐ Yes	☐ No
Were any limitations or special requirements imposed on you because of academic, incompetence, disciplinary problems or for any other reason?	☐ Yes	☐ No

Please explain any "Yes" responses from above:

____

____

Applicant: Print your complete last name: _____

17 Examination History

Provide the most recent examination date and total number of attempts for each examination you have taken for the purposes of state medical licensure.

Many applicants confuse NBME Parts with USMLE Steps. Please be certain to accurately report your examination history. Incorrectly reported examinations will result in delays and additional verification surcharges.

If you do not knopw the examination date, please write UNKNOWN next to the appropriate blocks.

Examination	Most Recent Attempt:	Pass/Fail/Unknown	No. of Attempts:
State Board Exam [1]			State: _____
FLEX Pre-1985			
FLEX Component 1			
FLEX Component 2			
LMCC - Single			
LMCC - Part I			
LMCC Part II			
LMCC Part A			
LMCC Part B			
NBME Part I			
NBME Part II			
NBME Part III			
NBOME COMLEX Level 1			
NBOME COMLEX Level 2 CE			
NBOME COMLEX Level 2 PE			
NBOME COMLEX Level 3			
SPEX			
USMLE Step 1			
USMLE Step 2			
USMLE Step 2 Clinical Skills			
USMLE Step 3			

1. State board examinations are those that were developed and administered specifically by state licensing authorities. Some states have never administered state board examinations and therefore do not apply. Most state medical boards did not offer a state board examination for licensure until after the early 1970s. Do not confuse these examinations with national licensing examinations such as NBME, NBOME or USMLE.

18. Recipient Designation

You must designate each professional licensing board, hospital, or other credentialing entity where you want your profile sent.

Addresses are not required for state medical boards.

You may photocopy this page for additional recipients.

☐ I am undecided about where my Profile should be sent (See "Undecided Applicants" on page 6 of the instructions).

☐ I wish to forward my Profile to the following state medical board(s):

* For Illinois, Kentucky, New York and South Carolina, see below.

1) _____ 5) _____

2) _____ 6) _____

3) _____ 7) _____

4) _____ 8) _____

☐ I wish to forward my Profile to the following entity, hospital or myself:

Complete name of recipient (do not abbreviate)

Contact (individual or department to whom your Profile will be addressed)

Street Address line 1

Street Address line 2

City State/Province

Country (U.S. or Canada only) ZIP/Postal Code Telephone (must be included)

☐ I wish to forward my Profile to the following entity, hospital or myself:

Complete name of recipient (do not abbreviate)

Contact (individual or department to whom your Profile will be addressed)

Street Address line 1

Street Address line 2

City State/Province

Country (U.S. or Canada only) ZIP/Postal Code Telephone (must be included)

*If you requested that FCVS forward your completed Physician Information Profile to the New York, Kentucky, South Carolina, or Illinois medical boards, please indicate the type of licensure you are seeking in the space below.

_____ Limited Permit in Medicine

_____ License in Medicine

_____ Faculty License

_____ Institutional License

_____ Admission to USMLE Step 3 examination in that state

_____ Three-year License to Practice in a Medically Underserved Area

_____ Training License

Applicant: Print your complete last name: _____

19. Fee Calculation

To avoid processing delays, please refer to pages 3 - 5 of the FCVS instructions (Fees).

If you are uncertain about any aspect of fee calculation, call 1-888-ASK-FCVS for assistance.

Refunds for overpayment will be initiated at the time your Profile is completed and shipped.

Method of payment: Check ☐ Money Order ☐

Check/Money Order # _____

Name on check: _____

A. Application fee (includes forwarding one Physician Information Profile) _____ 295.00

B. Paper application fee (applications **NOT** submitted online) $50 _____ 50.00

C. Fee to forward additional Physician Information Profile(s)

_____ Profiles x $60.00 each _____ .00

D. Examination Score Transcript Fee

1. USMLE Pre-1985 FLEX
   FLEX SPEX

_____ transcripts x $50.00 (1 - 2) _____ .00

2. NBME

_____ transcripts x $50.00 (1 - 5)

_____ transcripts x $5.00 (each additional) _____ .00

3. NBOME

_____ transcripts x $50.00 (each) _____ .00

4. Licentiate of Medical Council of Canada (LMCC)

_____ $95.00 (one time charge) _____ .00

5. State Board Examinations (indicate Board(s): _____)

transcripts (you will be billed separately for this once we determine the charge from the state board)

E. Institutional Adminstrative Fee

_____ $25.00 (one time charge) _____ 25.00

F. Shipping and handling (if applicable)

_____ Passport — $25.00 _____ .00

Total Fee Submitted: _____ .00

20. Required Documents

Please use this checklist to be certain you have submitted all required documents. Some may not apply.

- ☐ Resident Certificates
- ☐ Certified Birth Certificate
- ☐ Original Passport (with explanation)
  - ☐ sent with application
  - ☐ sent separate from application
- ☐ Documentation (or explanation) of Use of Alternate Name Form
- ☐ 8.5" x 11" Photocopy of Medical School Diploma
- ☐ Affidavit and Release and Authorization for Release of Information From Applicant Form
- ☐ NBME Examination History release
- ☐ Photocopies of Medical Education Documents

21. Signature

IMPORTANT:
Failure to complete this section will suspend all processing of your application.

I, the undersigned, hereby certify that I have read the "Instructions for Completing the FCVS Application" and agree to the terms and conditions set forth therein. I acknowledge that I have answered all the questions and reported all information in this application truthfully and completely.

Signature _____ Date _____

Federation of STATE MEDICAL BOARDS

Affidavit and Release and Authorization for Release of Information, Documents and Records

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have or shall make with respect thereto are true, that I am the original and lawful possessor and person named in the various forms and credentials furnished or to be furnished with respect to my application and that all documents, forms or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the "Instructions for Completing the FCVS Application" and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I waive confidentiality, authorize and request every person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me to furnish to the Federation Credentials Verification Service (FCVS) any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, my examination grades, or any other pertinent data and to permit FCVS or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application that can subsequently be provided to professional licensing boards, hospitals and other entities when I apply for licensure, staff membership, employment or other privileges.

I hereby release, discharge and exonerate FCVS, its agents or representatives and any person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by FCVS.

I will immediately notify FCVS in writing of any changes to the answers to any questions contained in this application if such a change occurs at any time prior to my FCVS Physician Information Profile being mailed.

Applicant Photograph

Securely tape or glue in this square a current, front-view, 2" X 2" passport-type color photograph of yourself

_____
Applicant's Signature (must be signed in the presence of a notary)

_____
Applicant's Printed Last Name

_____
Applicant's Printed First Name, Middle Initial, and Suffix (e.g., Jr.)

_____ _____
Date of Signature Date of Birth

_____
Applicant SSN

NOTARY

Your seal or stamp must be partly upon the photograph.

State of_____ County of _____

SUBSCRIBED AND SWORN TO before me this _____ day of _____ , 20 _____

My commission expires:_____

(NOTARY PUBLIC SIGNATURE & SEAL)

Notary Public signature:_____

I certify that on the date set forth above the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document.

Explanation of Alternate Name Form

Use this form to explain the use of any name(s) not supported by the identity document(s) submitted with your application. Do not write on the back of this form. If additional space is required, please make a photocopy(ies). Be certain to sign the form in the space provided at the bottom of the page.

Documented Name

The name reported here must be the name on your identity document (birth certificate or passport).

Last name (surname) and generational suffix

First and middle name

Last name (surname) and generational suffix

First and middle name

Explanation of use of name.

Last name (surname) and generational suffix

First and middle name

Explanation of use of name.

Last name (surname) and generational suffix

First and middle name

Explanation of use of name.

Signature

Signature

Date

Explanation of Other Activities During Medical Education

Please provide a complete, specific explanation regarding any other training or breaks between the beginning of your medical education and the final year of your postgraduate training. Dates should be reported in mm/yyyy format.

From: ☐☐ Month ☐☐☐☐ Year

To: ☐☐ Month ☐☐☐☐ Year

Activity _____

From: ☐☐ Month ☐☐☐☐ Year

To: ☐☐ Month ☐☐☐☐ Year

Activity _____

From: ☐☐ Month ☐☐☐☐ Year

To: ☐☐ Month ☐☐☐☐ Year

Activity _____

From: ☐☐ Month ☐☐☐☐ Year

To: ☐☐ Month ☐☐☐☐ Year

Activity _____

From: ☐☐ Month ☐☐☐☐ Year

To: ☐☐ Month ☐☐☐☐ Year

Activity _____

Signature (physician applicant)/Date _____

FCVS packet ID Number ☐☐☐☐☐☐

Clinical Clerkship

Complete this section if you did not graduate from a school accredited by the Liaison Committee on Medical Education or the American Osteopathic Association and if your clinical clerkship (training) was completed in a country other than where your medical school is located. List all clerkships attended. Please copy and use additional page(s) if required.

Complete name of affiliated university or college where clerkship was performed (Do not abbreviate).

Complete name of hospital, institution or individual where clerkship was performed (Do not abbreviate).

Address line 1

Address line 2

City

State/Province

Country

ZIP/Postal Code

From: Month Year

To: Month Year

Clinical Clerkship Area

Complete name of affiliated university or college where clerkship was performed (Do not abbreviate).

Complete name of hospital, institution or individual where clerkship was performed (Do not abbreviate).

Address line 1

Address line 2

City

State/Province

Country

ZIP/Postal Code

From: Month Year

To: Month Year

Clinical Clerkship Area

Voting Sheets

HOUSE COMMITTEE ON COMMERCE

EXECUTIVE SESSION on HB 636-FN

BILL TITLE: **relative to physician credentialing under the managed care law.**

DATE: March 20, 2007

LOB ROOM: 302

Amendments:

Sponsor: Rep. Flanders	OLS Document #:	2007	0798h
Sponsor: Rep.	OLS Document #:		
Sponsor: Rep.	OLS Document #:		

Motions: (OTP) OTP/A, ITL, Interim Study (Please circle one.)

Moved by Rep. Flanders

Seconded by Rep. Nord

Vote: 16-1 (Please attach record of roll call vote.)

Motions: OTP, (OTP/A), ITL, Interim Study (Please circle one.)

Moved by Rep. Flanders

Seconded by Rep. NOrd

Vote: 16-1 (Please attach record of roll call vote.)

CONSENT CALENDAR VOTE: Consent

(Vote to place on Consent Calendar must be unanimous.)

Statement of Intent: Refer to Committee Report

Respectfully submitted,

Rep. Stephen P. Spratt, Clerk

HOUSE COMMITTEE ON COMMERCE

EXECUTIVE SESSION on HB 636-FN

BILL TITLE: **relative to physician credentialing under the managed care law.**

DATE: {Type DATE} 3/20/2007

LOB ROOM: 302

Amendments:

Sponsor: Rep. FLANDERS — OLS Document #: 2007 0798h

Sponsor: Rep. — OLS Document #:

Sponsor: Rep. — OLS Document #:

Motions: (OTP) OTP/A, ITL, Interim Study (Please circle one.) AMENDMENT

Moved by Rep. FLANDERS

Seconded by Rep. NORD

Vote: (Please attach record of roll call vote.)

16 – 1

Motions: OTP, (OTP/A), ITL, Interim Study (Please circle one.)

Moved by Rep. FLANDERS

Seconded by Rep. NORD

Vote: (Please attach record of roll call vote.)

16 – 1

(CONSENT CALENDAR VOTE:) {Type VOTE}

(Vote to place on Consent Calendar must be unanimous.)

Statement of Intent: Refer to Committee Report

Respectfully submitted,

Rep. Stephen P. Spratt, Clerk

COMMERCE

Bill #: HB 656 Title: _____

PH Date: ___/___/___ Exec Session Date: 3/20/2007

Motion: OTP Amendment #: 2007-0798h

MEMBER	YEAS	NAYS
Reardon, Tara G, Chairman	✓	
DeStefano, Stephen T, V Chairman	✓	
Kopka, Angeline K	✓	
McEachern, Paul	✓	
Butler, Edward A	✓	
Hammond, Jill Shaffer	✓	
Houde, Matthew S	✓	
Matheson, Robert F	✓	
Nord, Susi	✓	
Spratt, Stephen P	✓	
Warren, Nancy H		
Winters, Joel F	✓	
Hunt, John B		✓
Belanger, Ronald J		
Flanders, Donald H	✓	
Clark, Charles L		
Quandt, Marshall E	✓	
Quandt, Matthew J	✓	
Martin, James R	✓	
Pelkey, Stephen T	✓	
	16	1

TOTAL VOTE:

Printed: 1/9/2007

COMMERCE

Bill #: HB 636 Title: _____

CH Date: 1/1/ Exec Session Date: 3/20/2007

Motion: OTP/A Amendment #: _____

MEMBER	YEAS	NAYS
Reardon, Tara G, Chairman	✓	
DeStefano, Stephen T, V Chairman	✓	
Kopka, Angeline K	✓	
McEachern, Paul	✓	
Butler, Edward A	✓	
Hammond, Jill Shaffer	✓	
Houde, Matthew S	✓	
Matheson, Robert F	✓	
Nord, Susi	✓	
Spratt, Stephen P	✓	
Warren, Nancy H		
Winters, Joel F	✓	
Hunt, John B		✓
Belanger, Ronald J		
Flanders, Donald H	✓	
Clark, Charles L		
Quandt, Marshall E	✓	
Quandt, Matthew J	✓	
Martin, James R	✓	
Pelkey, Stephen T	✓	
	16	1

TOTAL VOTE:

Printed: 1/9/2007

Committee Report

CONSENT CALENDAR

March 21, 2007

HOUSE OF REPRESENTATIVES

REPORT OF COMMITTEE

The Committee on COMMERCE to which was referred HB636-FN,

AN ACT relative to physician credentialing under the managed care law. Having considered the same, report the same with the following amendment, and the recommendation that the bill OUGHT TO PASS WITH AMENDMENT.

Rep. Donald H Flanders

FOR THE COMMITTEE

Original: House Clerk
Cc: Committee Bill File

COMMITTEE REPORT

Committee:	**COMMERCE**
Bill Number:	**HB636-FN**
Title:	**relative to physician credentialing under the managed care law.**
Date:	**March 21, 2007**
Consent Calendar:	**YES**
Recommendation:	**OUGHT TO PASS WITH AMENDMENT**

STATEMENT OF INTENT

This bill allows the health care provider who, at the time of application, has been licensed by the respective state licensing board and credentialed by the hospital, if appropriate, to deliver health care services to covered persons and seek reimbursement for such services, when covering on-call for another health care provider who is credentialed by the carrier. It also establishes a time frame for the carriers to act upon and finalize the credentialing process for primary care physicians and specialists.

Vote 16-1.

Rep. Donald H Flanders
FOR THE COMMITTEE

Original: House Clerk
Cc: Committee Bill File

CONSENT CALENDAR

COMMERCE

HB636-FN, relative to physician credentialing under the managed care law. **OUGHT TO PASS WITH AMENDMENT.**

Rep. Donald H Flanders for COMMERCE. This bill allows the health care provider who, at the time of application, has been licensed by the respective state licensing board and credentialed by the hospital, if appropriate, to deliver health care services to covered persons and seek reimbursement for such services, when covering on-call for another health care provider who is credentialed by the carrier. It also establishes a time frame for the carriers to act upon and finalize the credentialing process for primary care physicians and specialists. **Vote 16-1.**

Original: House Clerk
Cc: Committee Bill File

COMMITTEE REPORT

COMMITTEE: COMMERCE

BILL NUMBER: HB 636-FN

TITLE: RELATIVE TO PHYSICIAN CREDENTIALING UNDER THE MANAGED CARE LAW

DATE: 3/20/07 CONSENT CALENDAR: YES ☐ NO ☐

☐ OUGHT TO PASS

☒ OUGHT TO PASS W/ AMENDMENT

Amendment No. 2007-0798h

☐ INEXPEDIENT TO LEGISLATE

☐ RETAINED

☐ INTERIM STUDY (Available only 2nd year of biennium)

STATEMENT OF INTENT:

THIS BILL ALLOWS THE HEALTH CARE ~~PROFESSIONAL~~ PROVIDER WHO, AT THE TIME OF APPLICATION, HAS BEEN LICENSED BY THE RESPECTIVE STATE LICENSING BOARD AND CREDENTIALED BY THE HOSPITAL, IF APPROPRIATE, TO DELIVER HEALTH CARE SERVICES TO COVERED PERSONS AND SEEK REIMBURSEMENT FOR SUCH SERVICES, WHEN COVERING ON-CALL FOR ANOTHER HEALTH CARE PROVIDER WHO IS CREDENTIALED BY THE CARRIER. IT ALSO ESTABLISHES A TIME FRAME ~~LINE~~ FOR THE CARRIERS TO ACT UPON AND FINALIZE THE CREDENTIALING (Credentialing) PROCESS ~~WITHIN 30 CALENDAR DAYS~~ FOR PRIMARY CARE PHYSICIANS AND ~~45 DAYS FOR~~ SPECIALISTS

JSR

COMMITTEE VOTE: 16-1

- Copy to Committee Bill File
- Use Another Report for Minority Report

RESPECTFULLY SUBMITTED,

Rep. DON FLANDERS
For the Committee

Rev. 07/30/99